Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2009 May 0750 Linda Carol Smith /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Carroll Carroll Hospital Center Westminster If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, June 9 Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** <sup>Year)</sup> 1945 Days Hours Months 1 ☐ M 2 📆 Min. 215-42-6989 63 MD **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, Inc. Modical Evanian criust by confined at 1 Yes 2 No Director MD Carroll Westminster 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2017 Old Westminster Pike 21157 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 **X**No 1 ☐ Yes X☐ No Specify: <u>چ</u> Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Administrative Officer State of Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Health and Mental em 27 is marked o Melvin Collins, Sr Gladys Smoot 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4907 Buffalo Road Mt. Airy, MD 21771 Suzette Dorsey/executor Department of Heal Important: If item 2 any Injury or other 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/23/2009 Hampstead, MD Carroll Cremation, Inc 4 ☐ Donation 5 ☐ Other (Specify) ture of Funeral Service Lice Printed Rementation Home and Chapel, P.A. 21157 412 Washington Road Westminster, MD . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest k, or heart failure. List only one cause on each line. Imme late Cause (Final Physician 050 M disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or as a consequence of Exam sician and burial-tran Due to (or as a consequence of): physician Physician/Medical the as IF FEMALE: nse yes, outcome of pregnancy
Live birth 2 Fetal death
Fregnant at time of death
Chrown 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perforn 1 □ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 Dio 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27 Manner eath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Mitural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, After this To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun

Maryland 21215-0036

Baltimore,

Box 68760,

Ö

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Pages 1

State Registrar 29b. Signat

and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of-death (Item 23a) (Type, Print) Robert Rice PHD 68

Registrar's Signatu 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Montie 12:56 PM Scott May 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Frederick Memorial Hospital Frederick Frederick 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Hours Months 1 ☐ M 2 🖾 F Yrs. Director 578-01-6100 93 27,1915 Tennessee Aug. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, tre Medical Examinations to notified at Director 1 ☐ Yes 2 TNo <u>Maryland</u> Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with Funeral 4424 Oak Hill Road 20853 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. <u>Ş</u> 3 Widowed 4 Divorced Specify: White Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene. 7 is marked other than "" Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Grants Technical Assistant</u> Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ James Schotts Isia Galloway 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any injury or other tra Health a Martin Scott/ Son <u>4424 Oak Hill Road, Rockville, Maryland 20853</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory Inc 5/26/2009 Frederick, Maryland 22. Name and Address of Facility
Stauffer Funeral
1621 Opossumtown 21. Signature of Funeral Service Licenses Homes P. A. Pike, Frederick, Maryland 21702 Opossumtown 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** arrhythmia hours /Medical Due to (or as a consequence of): **Examiner** Coronary isease Sequentially list conditions, it cause. Enter Underlying Cause (Disease or injury that initiated events as the conditions of the condition Examine Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran resulting in death) Last Due to (or as a consequence of): attending physician P.O. Box 68760 Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) the 9 Unknown signed by t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, cate has been signal page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 1 □Yes 2 🗖 director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To After this funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Aatural 5 ☐ Pending investigation n 24 hours after death.

The Funeral Director: A pletely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year)

DHMH 17 Rev 1/2001

State Registrar

Rizvi, 31. Date filed (Month, Day, Year) MAY 2 6 2009

Fauzi

32. Registrar's Signature

Fauzi Rizvi, MO

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

MD 400 West 7th Street, Frederick, Maryland 21702

MDD 62180

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - State of Maryland / Depa State of Maryland / Depa Cer	rtment of Health and M <i>tificate of Death</i>		ene 2 0 0 9	18503
	Physici /Medic		Decedent's Name (First, Middle, Last)  JOSEPH WARREN SADLER, SR		2. Date of Death Month <b>MAY</b>	22 2009	3. Time of Death 12:02 P M
•	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	th
$\vdash$			313 CABLE HOUSE ROAD  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	STEVENSVILLE  If Under 1 Year If Under 24 Hrs.	8. Date of Birth		N ANNE'S
	Funeral Director		220-32-2221 1XM 2□ F 75 Yrs.	Months Days Hours Min.	(Month, Day, SEPTEMBER	24, 1933 M	thplace (State or Foreign ountry) ARYLAND
	land		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loc	eation			10d. Inside City Limits
	Maryi I-f sho	tor	MARYLAND QUEEN ANNE'S	STEVE	NSVILLE		1 ☐ Yes 2 <b>X</b> No
	h the	Director	10e. Street and Number	10f. Zip Code		Og. Citizen of What Co	ountry?
	23a c		313 CABLE HOUSE ROAD	21666		UNITED	STATES
ဟ	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental thygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, I're Medical Evan	Funeral	1 □ Never Married 2 🛣 Married   1 □ Yes 2 😿 No	Vas Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
21215-0036	hours a	ed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	☐Yes 2XNo Specify:		Specify: W	
<u>.</u>	in 72 n "nat	Completed	(Specify only highest grade completed) (Give k	ent's Usual Occupation kind of work done during most of worki OO NOT use retired)	ng	6b. Kind of Business	Industry
212	d with giene.	mo.	Elementary/Secondary (0-12)   College (1-4or 5+)	RTER BOAT CAPTAIN		MARITI	Æ
pu	should be filed and Mental Hygids smarked other anmatic event, II	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, N	laiden Surname)	
Maryland	should band Ment s marked umatic e	힏	REVERDY P. SADLER	ELIZAB	ETH HELE	N WHITE	
Mar	12 sh h and 7 is m traum			g Address (Street and Number or Rura		•	
	1 and Health em 27 other tu			CABLE HOUSE ROAD,		20c. Location - City or	
altimore,	Pages nent of int: If its iry or o		1 X Buriat 2 ☐ Cremation 3 ☐ Removal from State	atory or other place)  LLE CEMETERY  20	27.	•	LE, MARYLAND
Balti	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licensee	Name and Address of Facility	AND NEW	NAM FUNER	AL HOME, P.A.
				6 SHAMROCK ROAD,			Approximate
4.	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line.		,	2	Interval Between Onset and Death
1	/Medical		disease or condition resulting in death)  a.   Due to (or as a consequence of):	irillation			Minutes
	Examiner	_	Sequentially list conditions b. CONGULTINE He	ANT FAILURE			2 years
	ted isit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1			2 100
_in	execui n and al-trar	Examin	that initiated events resulting in death) Last  c.   C.   Due to (or as a consequence of):	orrhage			3 Months
68760	ificate be executed g physician and as the burial-transit	edical	a ATRIAL FIBRIL	LATION			10 years
		Medi				1 8	
Вох	leath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □	Ectopic pregnancy		23d. Date of de	
0	The law requires that the death cer ate has been signed by the attendin bage 2 should be detached for use a	Physician/M		Other (specify)		Month	Day Year
o.,	s that ned by deta		Part II. Other significant conditions contributing to death but not resulting in the und	derlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
g	w requires been sig should be	ed by	Aortic Aneurysm		1 □ Ye	s 2 No 3 ₽	robably 4 ☐ Unknown
Vital Records,	law re as be 2 sho	Completed			24a. Was ar		utopsy findings available completion of cause of
<u>~</u>	sician: The law certificate has birector, page 2 sl	E			perform	ned?   death?	2 No
ŽĮ.	ician: certifi ector,	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one	)	
<u></u>	nding Physician: th. : After this certifica ? funeral director, p	유 	1 ☐ Yes 2 1 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time of			nce 6 ☐ Other (Spe w injury occurred	ecify)
o	th. th. the tune	텵	Natural 5 ☐ Pending (Month, Day, Year) Injury 2 ☐ Accident investigation	Work? M 1 □Yes 2 □ No	zau. Describe no	w injury occurred	
Division of	Atter ector by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury At home, farm, stree			reet and Number or R	ural Route Number,
5	tal or rs afte al Dir led in	Cert	4 Homicide building, etc. (Specity)		City or Town	, State)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification pletely filled in by the funeral director, completely filled in by the funeral director, to	ledical	29a, Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or inversely and manner stated.	occurred at the time, date and place, estigation, in my opinion, death occurr	and due to the ca ed at the time, da	ause(s) and manner a ate and place, and due	s stated. e to the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Mon	h, Day, Year)
	(11.)		· Cepture (h)	D31997	0	5/26/	2009
	ĠΜ	ļ	30. Name and address of person who completed cause of death (Item 23a) (Type, PANDLEN GOLDON MD. 2003 MEDICAL P	PRING Stepp A.	INAPOI	CMD	21401
	Sta	е	31. Date filed (Month, Day, Year) 32 Registrar's Signature	3 100, 111	1.11.00	1	
	Registra	ır	MAY 26 2009 Satura S. San	Kal			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Item 29d State of Maryland / Department of Health and Mental Hygiene 1- State WCHD/SH 6/5/09 per Dr. Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Day Year **Physician** Toms, Jr. 2:55 PM Harry LeRov Mar 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Washington Hagerstown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 81 Director 220-30-9973 Maryland 1928 January 4, Usual Residence of Decedent 10a. State 10b. County 10c City Town or Location show 10d. Inside City Limits 7 is marked other than "natural" or items 23a or 28a-f sh traumatic event, the fire dient Extending must be notified Director 1 ☐ Yes 2 X No Maryland Washington Boonsboro the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8507 Mapleville Road 21713 U.S.A. Funeral should be filed within 72 hours after death v 12. Was Decedent Ever in U.S. Armed Forces?

1 ★Yes 2 □ No 1946—
If Yes, Give Year or Dates: 1947 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify à Specify: 3 Widowed 4 Divorced White 1947 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, If a 1% once. Elementary/Secondary (0-12) College (J-4or 5+) Dairy Farmer Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ LeRoy Elizabeth Connally Harry Toms, Sr. Leps 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19746 Toms Road Harry L. Toms, III Boonsboro, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/29/2009 Stauffer Crematory Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bast-Stauffer Funeral Home, 7606 Old National Pike Boonsboro, MD 21713 23a. Part 1. Enter the disease, or conshock, or heart failure. List only tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** YMIC disease or condition resulting in death) /Medical Due to ( r as a consequence of): Examiner Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a colliseque rice or) The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ੬ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 2 No 1 ☐Yes 2 ☐No 1 ☐ Yes e Hospital or Attending Physician: 124 hours after death, e Funeral Director: After this certifical letely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suîcide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ပ 5/27052323 Name and address of person who completed cause of death (New 23a) (Type Print) Court, Hagers Town, mo 21740 WH 1041 31. Date filed (Month 32. Redistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month\_ 1)320 M **Physician** TURNER LTON 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Arundel Mandrin Chesapeake Hospice House Harwood Anne 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9/11/1931 9. Birthplace (State or Foreign **Funeral** 1**Z** M 2□ F Months Days Hours Min. 212-30-6386 Director Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25 Arbor Hill Rd. 21403 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 2 Specify: 3 ₩ Widowed 4 Divorced Year or Dates: 1954-56 White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Auto Mechanic Automobile Repair 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Herman Turner, Sr. Edna C. Phipps ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 siment of Health an Vicki L. Turner/ Daughter 5854 Solomons Island Rd., Tracys Landing, MD 20779 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lakemont Cemetery 5/23/09 Davidsonville, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Icensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician mon disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Box 68760, signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) Pregnant at time of death P.O. ☐Yes 2☐No 9 Unknown 9 Dlnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? s certificate has t irector, page 2 s 24a. Was an 2 ∏ No 1 ☐ Yes 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other 1 Yes 2 No PILL 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred House 1 Natural 2 □ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the

State

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Name and address of p

32. Registrar's Signature

445

erson who completed cause of death (Item 23a) (Type, Print)

al ENTAMD

EXENSE HAHWAY ANNAPOLU

29d. Date signed (Month, Day, Year)

Registrar

29c. License number

021438

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 7:35 a <sup>M</sup> May 22, 2009 Elaine A. White /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Montgomery Suburban Hospital Bethesda 8. Date of Birth (Month, Day, Year) Feb. 14, 1 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number Country)
Mass. Funeral Months Days Hours Min 1 □ M 2 🖾 F 1927 Director 034-20-2520 82 Usual Residence of Decedent death with the Maryland 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location show ms 23a or 28a-f sho 1 AYes 2 No Director Rockville MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20852 USA 10763 Brewer House Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. In the filed Research if item 27 is marked other than "natural", or ite my or other traumatic event, It a Maritea Examinatiny or other traumatic event, Its Maritea Examina 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 white 1 ☐Yes 2X No Specify 2 Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Real Estate 12 Agent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harold Arnold Anna Friedman 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10763 Brewer House Road, Rockville, Maryland 20852 Scott White, son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 🖾 Cremation 3 🖾 Removal from State Department of Important: If any injury or National Crematorium 05/27/2009 Falls Church, Virginia 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Danzansky-Goldberg Memorial Chapels, Inc. Signat in of Funeral Service Licensee MO1255 20852 1170 Rockville Pike, Rockville, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PS US Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit LESTIVE HEART FAILURE 7:35a Box 68760, Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ Ro Year Day 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 2 1 ☐ Yes 2 🛣 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 No 1 ☐ Yes of Vital filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 100 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Ampatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? after death.

Director: After Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide P Hospital of 24 hours a Puneral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier To the Hosp within 24 hor To the Fune completely fi Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00057124 5/22/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Troung Bao, 10110 Molecular Drive, #206, Rockville, Maryland 31. Date filed (Month, Day, Year) Registrar's Signature State MAY 26 2009 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** William Carl WETTSTEIN Sr. 1:50 a. May 28, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 16810 Longfellow Court Hagerstown Washington 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Days Months 1 X M 2 □ F 145-34-8437 64 Director July 4, 1944 New Jersey Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 □Yes 2X No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16810 Longfellow Court 21740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 X No ģ Specify. 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) foreman telecommunication permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked ofth any lipiry or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Francis Wettstein Dora Kessler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Wettstein - wife 16810 Longfellow Court, Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 IXCremation 3 ☐ Removal from State Hagerstown Crematory: 5/28/09 4 □ Donation 5 □ Other (Specify) Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** month /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner I or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1∏ Yes 2 4 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DH-6 State

DHMH 17 Rev 1/2001

Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Louis C. Woyce, Jr. 5 11:00 A M 24 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Atlantic General Hospital Berlin Worcester 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3/27/1928 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1**XXX**M 2□ F Hours 81 Yrs. 209-14-2976 PA **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland Hyglene. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Directo Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11421 Terrapin Point Rd. 21811 USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 □XYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 21215-0036 1∐Yes 2∐XNo Completed by Specify 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Salesman Office Products Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Health and Mental Louis Woyce, Sr. Helen Coleman t of Health and 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Suzanne Haldan / daughter 10040 E. Happy Valley Rd., Scottsdale, AZ 85255 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othe (Specify) Cape Henlopen Crem. 5/25/2009 Frankford, DE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 Approximate Interval Between Onset and Death 23a. Part 1. Box the risease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, if the ar failure. List only one cause on each line. Immediate Cause (Final **Physician** neumoni day disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) ending physician and use as the burial-tran Due to (or as a consequence of) Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) ☐Yes 2 ☐No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed Cancer 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy 2 No 1 □ Yes of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manper of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred Woycedr 5 Pending investigation 1 M Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 \* Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number au, d D0062670 30. Name and address of person who mpleted cause of death (Item 23a) (Type, Print) Suite 101 DH 9+1 reder MD Pocomoke, MD 21851 500 Minket St

Registrar DHMH 17 Rev 1/2001

State

5/24/09

32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene -1 - State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Mayth 24 2009 6:16ам Johnny Ray Wilkes 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore Gilechrist Center Hospice Care Baltimore If Under 1 Year | If Under 24 Hrs. 9, Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Days Hours Min Nor Th Carolina **№** M 2□ F 60 216 58 0066 11/18/1948 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location Baltimore 1 Yes 2 □ No MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21223 1527 Penrose Avenue 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status 1 □Yes 2 □XNo If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Specify: Black 1 ☐ Yes 2 🔀 No Specify 3 ☐ Widowed 4 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cleaning Co. Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sadie Speight Ernest Wilkes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 404 Liberty Ave. Snowhill, NC 28580 Rosa Wilkes/Sister in law 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State Hamilton\_Gardens 5-30-2009 Wilson, NC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sconner Memorial Snow Hill, NC 28580 P.O Box 205 21. Signature of Funeral Service Ligenses M00902 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart safure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) UNG Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed: 2 🗆 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Dath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury 1 Natural 2 Accident 5 Pending investigation

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Division of Vital Records, P.O. Box 68760, attending physician the signed by

death.

**Physician** /Medical

> page 2 should be certificate has After this within 24 hours after deatl To the Funeral Director: filled in by the

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

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Examiner

Physician/Medical

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Completed

Be

Certification: To

Medical

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantment must be notified at

and manner stated

1 ☐ Yes 2 ☐ No Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Blod/Balt

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier (Check only one)

3 Suicide

4 - Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, 262009

6 ☐ Could not be

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May **Physician** 23 Day 7:49 P INEZ DORA MONTGOMERY WARREN 200 /Medical 4a. Facility Name (If not institution, give street and number) or Location of Death County of Death Examiner CHARLE ENTER APLATA IVISTA If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. MAX 24, 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2√2 F 76 1932 MARYLAND 219-36-8032 Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Madical Examiner must be notified at Director 1 ☐ Yes 2 ▼No MARYLAND CHARLES INDIAN HEAD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country's 5377 NELSON POINT ROAD 20640 UNITED STATES Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 72 hours after 1 Never Married 2 Married 21215-0036 1 □Yes 2 No Specify è Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within and Mental Hygiene. 12TH GRADE (0-12) College (1-4or 5+) CHILDCARE PROVIDER CHILDCARE marked other Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CLARENCE MC GRUDER DOROTHY CORRAINE MONTGOMERY WASHINGTON 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a CHESTER WARREN / HUSBAND 5377 NELSON POINT ROAD, INDIAN HEAD, MARYLAND 20640 Pages 1 and Department of Heal Important: If item 2 any Injury or other Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State SMITH CHAPEL CHURCH CEMETERY MAY 28, 2009 PISGAH, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Stringture of Funeral Sergio Licensee THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 32 LYDIA C. THORNTON JOHNSON MO0583 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) nce of) /Medical Due to (or as a conseque Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of physician and the burial-transit Due to (or as a consequence of): Physician/Medical attending ph for use as th IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) the 1 ☐ Yes 2 💋 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ð 1 🗌 Yes 2 No 3 Probably 4 I Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No 24a. Was an has 2 s autopsy performe certificate ha 2 🗖 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 1 Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 within 24 hours after death

To the Funeral Director:
completely filled in by the

DNEZ

LACEN

State

29b. Signature and title of certifier

29c. License number 100083

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Paul E Pritchett Sr. MD 118 LAGRange Ave PoBox 1317 La Plata, Md raul E 31. Date filed (Month, Day, Year)

Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

Medical

5 Pending investigation

6 ☐ Could not be

determined

1 Natural

2 Accident 3 Suicide

4 ☐ Homicide

(Check only one)

32. Registrar's Signature MAY 26 2009

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Lester E. Wagaman 9 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 10 Bunt Q WY Y Baltimore Washington Medical Center If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Min. Days 1√5 M 2□ F 213-16-0430 89 PA 9/7/1919 Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location 1 ☐ Yes 2x No MD Anne Arundel Gambrills 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21054 USA 929 Autumn Valley Lane Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 MYes 2 Nol 939—
If Yes, Give
Year or Dates: 1966 1 Never Married XX Married 1 ☐ Yes 2 ₩ No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) NSA 12 Security 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lucy Rosenberger Harry M. Wagaman 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 929 Autumn Valley Lane Gambrills, MD 21054 Spouse Mary Wagaman 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville, MD Maryland Veterans Cem 5/21/2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Sovice Licensee Annapolis, MD 21401 12 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Year Month Day in the past 12 months? 1 □ Yes 2 □ No 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy perform 1 ☐ Yes 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending

Physician /Medical Examiner

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item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinating to rectified at

Baltimore, Maryland 21215-0036

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burialthe as attending for use signed by 1 d be detach page 2 should has certificate After this certification funeral director, p within 24 hours after death.

To the Funeral Director: A filled in by the

Physician: The law requires that the death certificate be executed

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Division of

**Hospital or Attending** 

Examiner Physician/Medical ş Be Completed Certification: To

Medical

State Registrar

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25.	Was	case	referred	to	me	dical

examiner? 1 Yes 2 □ No

1 Natural Accident

3 Suicide 4 ☐ Homicide

investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year) (May 11, 2004 28e. Plac of Injury - At home, building, etc. (Specify)

G. OopM farm, street, factory,

1 ☐ Yes

Location (Street and Number or Rural Route Number City or Town, State) 28f. City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29b. Signature and title of certifie

29d. Date signed (Month, Day, Year)

30. Name and address of

31. Date filed (Month, Day, Year)

**Physician** /Medical 4a. Facility Name (If not institution, give street and number) Examiner Baltimore-Washington Medical Center 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 0 F 216-03-4379 4749 94 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Waddel Exprised... ust by netitied at once. Maryland Anne Arundel Director 10e. Street and Number 1764 Bayside Beach Road by Funeral 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 3 Midowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 17. Father's Name (First, Middle, Last) Be DARIGE Gaston Thompson 2 19a. Informant's Name/Relationship (Type. Print) Anderson (Daughter) Donna Κ. 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 23a. Part. Enter the disease, or complications that caused the death. **Physician** 

1 - For State Registrar

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month 2009 VI 10 A.M. MARIAN V. ANDERSON 4c. County of Death 4b. City, Town, or Location of Death Anne Arundel Glen Burnie If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Hours Days Min. Months: December 17.1914 Marvland 10d. Inside City Limits 1 ☐ Yes 2 No Pasadena 10f. Zip Code 10g. Citizen of What Country? 21122 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Specify: White 1 □Yes 2**A** No Specify 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) Kathryn Frantz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1764 Bayside Beach Road, Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other pla 20c. Location - City or Town, State Moreland Memorial Park 06-10-09 Parkville, Maryland 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ediate Cause (Final Dumby 23 disease or condition resulting in death) Eug Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of) Exami Due to (or as a consequence of) Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy DINER YR 2 X No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide cal 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 96372L MY WANDY 1406 CRMN BURNIE MEDN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #5 per FH G893 7/7/09 TT

State of Maryland 7 Department of Health and Mental Hygiene 2 0 0 9

Certificate of Death

Reg. No.

Registrar

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cate has been signed page 2 should be det

certificate

After this certification, page 1

within 24 hours after death.

To the Funeral Director: /
completely filled in by the fi

Examiner

the Hospital or Attending Physician: The law requires that the death certificate be executed

Box 68760,

P.O.

Division of Vital Records,

31. Date filed (Month, Day, Year)

32/Registrar's Signature

State of Maryland / Department of Health and Mental Hygien ? 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 7000 7572 M Donald Clark Abey, Sr. nnf /Medical County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ten 6 Bhrni nne Baltimore Washington Medical Cen. If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Funeral 6. Sex ( Year) Min. 1 M 2 □ F Months Days Hours 75 Maryland 215 30 8468 Director 06/06/1934 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h. County show in than "natural", or items 23a or 28a-f show Director Anne Arundel Glen Burnie 1 ☐Yes 2X No Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 109 Oak Avenue 21061 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

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If Yes, Give
Year or Dates: Black, White, etc. and 2 should be filed within 72 hours after 1 □ Never Married 2 □ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 V No Specify þ 3 X Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Machinist Manufacturing 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental h John Abey Jessie Kendall မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Dawn Arnold / Daughter 8232 Forest Glen Drive Pasadena, Maryland 21122 20c. Location - City or Town, State permit. Pages 1 a
Department of He
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any injury or oth
once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park: 06/11/2009 | Glen Burnie, Maryland 22. Name and Address of Facility 21. Signature of Juneral Service bi Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory agrest, shock or heart failure. List only one cause on each line. enktyni Immediate Cause (Final omonou OVI **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-transit certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 C Ectopic pregnancy Day 5 Other (specify) sate has been signed by the a page 2 should be detached to 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u></u> 2 1 0 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 ☐ Yes 215 No 2 No of Vital spital or Attending Physician: 1 hours after death. neral Director: After this certifica y filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 15 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral L 29a, Certifier r **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ■ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of dertifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 U 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20c Per FH G892 6/10/09 JH
State of Maryland / Department of Health and Mental Hygiene 1 - State AMEND ITEM#20b-c&#22,perFH,G893,7/16/09 Wifficate of Death

1 - Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month 2009 **Physician** 8:03 AMM June 1, Agnes Agyire /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery 01ney 8 Dumfries Court If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours 1 ☐ M 2 🖾 F Davs Director 217-53-0033 6/4/1960 Ghana Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City. Town or Location 10b. County 1XYes 2 No Director 01ney Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Funeral 8 Dumfries Ct. 20832 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give T Year or Dates: Specify Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed years Private Duty Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Issac Owoo Agnes Dowvona 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
D. partment of Health a
In portant: If item 27 is
any injury or other trai 2825 Terrace Dr. #102 Chevy Chase MD 20815 Jackson Agyire/Husband 20b. Place of Disposition (Name of Cemetery, crematory or other place)

Gate of Heaven Cemetery 7/11/09 20c. Location - City or Town, State 20a. Method of Disposition Spring, MD 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Silver 4 ☐ Donation 5 ☐ Other (Specify) Hines Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave. Silver Sring, Md 20904 4217 9th St. NW Washington DC 20011 21. Signature of Funeral Service Licensee 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Du t Vor as a consequence of): disease or condition resulting in death) CON GOVOSCULGI /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and initiated events. Physician/Medical Examiner Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) IF FEMALE: If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) Signature and title of certific

State Registrar 31. Date filed (Month, Day, Year)

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filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore.

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death Rea. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** MICHAEL ANOFF 740 me /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) 03/19/1953 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Country) MD 1 X M 2 ☐ F Days Hours 218-56-0253 Director 56 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Evaminer must be notified at 1 X Yes 2 □ No Director BALTIMORE MD N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21215 6903 REISTERSTOWN ROAD USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 □Yes 2 X No Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) JANITORIAL CUSTODIAN 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any lighty or other traumatic event once. 17. Father's Name (First, Middle, Last) Be **ANOFF** BONNIE MERDLER MELVIN ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BONNIE KAHAN / MOTHER 8804 JOSHUA COURT, BALTIMORE, MD 20b. Place of Disposition (Name of ANSHE Place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State 06/08/2009 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) AITZ CHAIM 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pt IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 ☐ Unknown care nas been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐Yes 2 No 1 □Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) SEASONS HOSPICE examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ANatural 5 Pending investigation To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year)
June 5th 2009 29b. Signature and title of certifier 29c. License number

State

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Mon

Ave Sulte 203 Balkmore MD 21209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W Debbie Burton 2835 Smith

32 Registrar's Signatu

**Physician** Examiner Division of Vital Records, P.O. Box 68760,

or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans attending pl signed by the a certificate has been s rector, page 2 should filled in by within 24 hours a

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**Physician** 

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ompieted	CONGESTIVE ITEM	MI FAILME		24b. Were autopsy findings available prior to completion of cause of death?					
5	NON INSULIN !	DEPENDENT DIABETES	MELLITUS	performed? 1 ☐ Yes 2 ☐		No			
ge	25. Was case referred to medical examiner?		26. Place of Death	h (Check only one)					
0	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	☐ DOA Other: 4 ☐ Nursing Ho	me 5 Residence	6 Other (Specify)	s ito spice			
ation:	2 LI Addition	f Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28c. Injury at Work?			28d. Describe how injury occurred				
Certinic	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		actory, office	28f. Location (Street City or Town, Sta	and Number or Rural Ro ate)	oute Number,			
ealcal		hysician: To the best of my knowledge, death occ miner: On the basis of examination and/or investi and manner stated.							
Ξ	29b. Signature and title of certifier		29c. License number	29d. [	Date signed (Month, Day	Year)			

State Registrar

JUN 1 0 2009

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

em 23a) (Type, Print)
2835 SMUTH AVE SUITE ZOS BULTIMORO MP swton 32. Registrar's Signature

H45931

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 1-20 AM **Physician** Florine Brown 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A **Baltimore** 762 Carroll Street If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, **Funeral** Year) Days Hours Min 1 □ M 3 □ F Feb 6, 1925 So. Carolina Director 220-24-6017 84 Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City. Town or Location 10a. State th and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinations used be notified at 1X Yes 2 □ No Director Baltimore N/A Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21230 762 Carroll Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 😿 No Specify: Black à 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Own Home College (1-4or 5+) Elementary/Secondary (0-12) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fannie Jones James Moulten ္က 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health a if item 27 is or other train 762 Carroll Street Baltimore, Maryland 21230 Lilly Brown Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition = 5 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important; If any injury or once. Owings Mills, Md. 06/12/09 Garrison Forest Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Pervice Lic Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 6 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastate disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of: Physician/Medical Examiner burial-transit Due to (or as a consequence of): physician a attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months?
1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 X No 3 Probably 4 Unknown PIREC Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2√ No 24a. Was an autopsy performed? 1 □ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Division of Vital Records, P.O. Box 68760.

Hospital or Attending Physiclan; The law requires that the death certificate be executed this After 1 after death

Director: n 24 hours after le Funeral Dire bletely filled in b

death v

Pages 1 and 2 should be filed within 72 hours after

altimore, Maryland 21215-0036

State Registrar

Medical

4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JUN 10

29a, Certifier

(4 wither man 43 DC

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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and manner stated.

4940 32/ Registrar's Signature

within 2 the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🖺 🖺 Certificate of Death 2. Date of Death

21215-0036 Maryland 2 Manovagu 6600 Baltimore, Mai

> certificate be executed sician and burial-trans attending physician for use as the buria ificate has been się r, page 2 should b this certificate

Ö Records, Vital the Hospital or Attending Physician: hin 24 hours after death. Division of 0 the

3. Time of Death 1. Decedent's Name (First, Middle, Last) 2009 JUNE 7 5:30a M **Physician** BILLEB EVERETT /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE MANOR CARE ROSSVILLE ROSEDALE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/03/1926 9. Birthplace (State or Foreign Country)
NEW YORK 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1**X** M 2 □ F 82 Director 203189465 Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Evandary injury or other traumatic event. 10b. County 10c. City, Town or Location 1X Yes 2 □ No n/a BALTIMORE MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21218 USA 3501 ST PAUL STREET by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give WW II Year or Dates: WW II 1 Never Married 2 Married 1 ☐Yes 2 No Specify: WHITE Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) MACHINIST TOOL & DYE 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CHARLES BILLEB AGNES TREIBER ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5005 EAST HOFMAN STREET BALTIMORE, MD ROSEMARI RIOS /SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State 6/9/08 BALTIMORE, MD METRO CREMATORY 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Sovice Licensee 1211 CHESACO AVE BALTIMORE, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 257727 6/7/09 nom Woods Road. MD 21234 30. Name and address of person who completed cause of death (Item 23a) (Type, Print & Wall) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 26,27,30 per dr., 2892,06/10/09dhb Reg. No. 26/10/09dhb 1 - For State Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) May 15, 2009 8:00 PM M **Physician** Catherine Brilhart /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Manchester 2866 Hilltop Drive If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 85 Mar 3, 1924 Maryland 219-10-7565 Director Usual Residence of Decedent 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evanticer must be notified at aging. 1 ∐Yes 2√∑No Funeral Director Carroll Manchester 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2866 Hilltop Drive 21102 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2∭ No Specify. Specify: white à 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) electronics assembler 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Andrew Deinlein Alice Ernestine Patterson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2866 hilltop Drive Manchester, MD Catherine Bowler/niece Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 N Donation 5 ☐ Other (Specify) 21. Signature of Fonaral Service Liver Ronal 1 22. Name and Address of Facility Wad State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Baltimore, MĎ 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate duse (Final disease or condition resulting in death) **Physician** Holenconteineme /Medical Due to (or as a consequence of **Examiner** Due to (or as consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 ☐ Other (specify) P.0. ed by the detached f 1 ☐Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? certificate has been signed rector, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 3 ☐ No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner' Hospital: Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A investigation 2 Accident filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Teresa Hanyok, M.D., 2973 Manchester Rd., Manchester, MD 21102

MI

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

5

29c. License number

29d. Date signed (Month, Dav. Year)

Do 20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 11:45 AM **Physician** Ronald Wayne Burns 7 2009 June /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/A Baltimore Union Memorial Hospital 9. Birthplace (State or Foreign Country) West Virginia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1**X**□ M 2□ F 68 Yrs. 03/16/1941 217 38 5739 **Director** Usual Residence of Decedent 10d. Inside City Limits 72 hours after death with the Maryland 10a. State 10h. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Madical Examiner must be redified at 1X Yes 2 □ No Director Baltimore N/A Marvland 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21226 3603 Everett Street Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. permit. Pages 1 and 2 should be filled wit Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, It and Injury or other ev Warehouse Worker Shofers Furniture 9th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emmanuel L. Burns Marguerite Smith ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Maryland 21225 Diana Simms / Niece 106 - 10th Avenue Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 Removal from State 06/09/2009 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service I 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Peath Immediate Cause (Final disease or condition resulting in death) Septal **Physician** lak /Medical Due to (or as a consequence of): Examiner te Myo Cardi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed Multiorgan and burial-trar Due to (or as a consequence of): physician Box 68760 Physician/Medical the attending pl If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. ed by the detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been si page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Ves 2 No certificate 1 ☐Yes 2 ☐No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2**X**No 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending investigation 1 □Yes 2 □No 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 ☐ Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

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Union Memorial Hospita

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State of Maryland / Department of Health and Mental Hygiene UU9

1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Day Month Year **Physician** 8:25P M 2009 05 06 Irene Bessie Brown /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** Montgomery Silver Spring, MD Woodside Nursing Home If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5/7/1914 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex Days **Funeral** Months 1 ☐ M 2 🔯 F DC Director 578-22**-**5666 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 28a-f show other traumatic event, the Medical Examinar must be notified at 1X Yes 2 No Director DC. None Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural" ~-" any injury or other traumatic ave." ò USA or items 23a 20011 NW 128 Quakenbos St. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. ☐Yes 2 No Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify Specify: Black þ 3₺ Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 2 years Elementary/Secondary (0-12) years Private Part-time Nurse 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Ella N. Bates Oscar D. Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 908 S Belgrade Rd Silver Spring MD 20902 Norma Robinson/cousin 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/15/2009 Culpeper, VA Culpeper Nat. Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home 4217 9th St. NW Washington DC 20011 pmanhall 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 2yrs Congestive Heart Failure disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Hypertensive Cardiovascular Disease 20yrs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The faw requires that the death certificate be executed 20yrs Generalized Arteriosclerosis use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical d. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months?
1 Yes 2 No ō 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknow signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 😧 No 3 Probably 4 Unknown Vascular Dementia Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate has 1 ☐ Yes 2X No To the Hospital or Attanding Physician: the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 ☐ Yes 2 ☐ No this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 5 Pending investigation 1 Natural 1 Yes 2 No after death. 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funaral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier gine 08, 2009 1 Zelter XMD25586 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E. DeVaughn Belton MD 1629 Columbia Rd. NW Ste 334 Washington DC 20009 31. Date filed (Month, Day, Year) 2. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JUN 1 n 2009

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 04:00 A.M TUNG -009 6 Jeheva STOWE 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) HOSPITAL BALTIMORE ST. AGNES 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours Min. 1 □ M 2 🗓 F North Carolina Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 XYes 2 ☐ No MORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify 3 N Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First. Middle, Last) 19b. Mailing Address (Street and Number or Rural Poute Number, City or Town, State, Zip Code) /Son) Informant's Name/Relationship (Type. Print) City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12009 6/11 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Home 23a. Part 1/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ardiomyotothy lant Sided dilated Immediate Cause (Final disease or condition resulting in death) or as a consequence of) months nal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) NEON ortoria Due to (Ir as a consequence of) mon this teratric IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes ebro vascular 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □ Yes 2 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one 2QM Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Box 68760 P.O.

Division of Vital

the attending physician hed for use as the burial After this certificate has been signed by funeral director, page 2 should be detact

Physician/Medical

≥

Completed

Be

Certification: To

Medical

the

completely filled in by

1 Natural

2 ☐ Accident

3 Suicide

29a, Certifier

4 Homicide

(Check only one)

**Physician** 

/Medical

**Examiner** 

Director

Funeral

ð

Completed

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marical Examirer must be notified at once.

**Physician** 

/Medical

Examiner

3altimore, Maryland 21215-0036

e Hospital or Attending Physician: 24 hours after death. 9 Funeral Director: After this certifica To the I within 2

State Registrar 29b. Signature at

5 Pending investigation

6 ☐ Could not be

and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 30335878

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1641 10ma

Coton Avenue Baltimore, ND 21229 900

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month; Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? | | 9 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 3:30 AMM 2009 William Edward Becker June 8, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 1912 Haverhill Rd. Parkville Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. 12XM 2□ F 76 11/03/1932 NY Director 068-26-8662 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show ral", or Items 23a or 28a-f shov Ever, ingranged at 1 ☐ Yes 2 → No Director MD Baltimore Parkville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1912 Haverhill Rd. USA Funeral 12. Was Decedent Ever in U.S. Armed Ferces? 1 ♣ Yes 2 □ No If Yes, Give Year or Dates: 1953 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1∐Yes 2⊠K√o Specify þ Specify: 3 Widowed 4 ☐ Divorced 1953-1955 White Completed other traumatic event, the Medical 16h Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Computer Imaging Elementary/Secondary (0-12) College (1-4or 5+) President of BEKR Industries marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be August Becker Elizabeth Stryker ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eric Becker/Son 1912 Haverhill Rd. Parkville, MD 21234 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Jun Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2009 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician METASTATIC SMALL CELL LUM CANCER WEEKS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or, Examine sician and burial-transit Due to (or as a consequence of): Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Tyes 2 No the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □ No 24a. Was an page 2 autopsy performed? Yes 225No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 2 Accident 5 Pending 1 □Yes 2 □ No investigation 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated

State Registrar

Box 68760.

P.O. I

Records,

Division of Vital

31. Date filed (Month, Day, Year)

DOBERMAN

MO

on who completed cause of death (Item 23a) (Type, Print)

555

29b. Signature and title of certifier

30. Name and address of pe

32. Registrar's Signature Thorn A. falls

D64395

W TOWSONTOWN BLUD BACTIMORE, MO 21204

09-04344 Keirra Bonner Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 18524

		For State	Certif	ficate of Death		Reg. No. 2 Date of Death 3, Time of Death			
Physicia edical Exami	an/	Decedent's Name (First, Middle	hovmaine	Bonner	2. Date of Death Month D May 31, 200	Month Day Year 1449 hrs May 31, 2009			
		ta. Facility Name (if not institution		4b. City, Town, or Location Baltimore	of Death	4c. County of Dea			
Funeral Director		5. Social Security Number	6. Sex 7. Age (In yrs. last	t birthday)  If Under 1 Year I		9. B 9005	irthplace (State or ign ountry)		
w any		Usual Residence of Decedent  10a. State  10b. County	10c. City, To	own or Location			10d. Inside City Limits 1 Yes 2 No		
th the Maryland 23a or 28a-f show any notified at once.	rector	10e. Street and Number	- Exe	10f. Zip Code	10g	. Citizen of What Co	ountry?		
h with the mrs 23a or	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	. 13. Was Decedent of Hispanic O	rigin? ( Specify Yes or No- an, Puerto Rican, etc.)	14. Race - Am White, etc.	erican Indian, Black,		
after deatl al", or ite iner must	by Fun	3 Widowed 4 Div	vorced If Yes, Give Year or Dates:	1 Yes 2 No special Security 16a. Decedent's Usual Occupation (Given		Specify: £	S/ACKs/Industry		
36 in 72 hours af han "natural lical Examin	ompleted I	15. Decedent's Education (Spe Elementary/Secondary (0-12)	,,	during most of working life. DO NO	OT use retired)	Chil	1		
Dre, MD 21215-0036 es I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygens, it filem 27s and American Chan "natural", or items 23a or 28a-f she her transmatic event, the Medical Examiner must be notified at once	Be Com	17. Father's Name (First, Middle	evin Bonner	m	ner's Name (First, Middle, M	e Gua	Sellow		
MD 212 d 2 should b Ith and Meni n 27 is marl	101	19a. Informant's Name/Relation Micheal H	evin Bonner	19b. Mailing Address (Street and N	lumber or Rural Route Number	per, City or Town, St 2/fo 7/1/ 20c. Location - City	1 21213_		
of H		20a. Method of Disposition  1 Burial 2 Crematic  4 Donation 5 Other S	n 3 Removal from State Mt.cr	rematory or other place)  Carmel Cemetery	6/25/09 ← <del>\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \</del>	Baltm	ore MD		
Baltimo permit. Pag Department Important:		21. Signature of Funeral Service	e Licensee	22. Name and Address of Fac Funeral Sur	P.A. 2431	E. Oliver	St-Bouto Mil Approximate Interval		
Physician Undica	00.5	23a, Part I. Enter the disease, of failure. List only one caus Immediate Cause (Final diseas)	Wathadana int		is cardiac or respiratory arre	St, Shock, of Heart	Between Onset and Death		
Jamine		or condition resulting in death) Sequentially list conditions,	Due to (or as a consequence of) b						
	Examiner	if any, leading to immediate  Course Frank Underlying Caus  (Disease or injury that initiated	Due to for as a consequence of						
executed in and I - transit		events resulting in death) Last  X UNPENDED		per Fh, 23a,27,28	a-f,perME, g	393 7/22/0	09 TT		
Box 68760, e death certificate be execut the attending physician and refore nee as the burial. Ira	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in past 12 months?	the 23c. If yes, outcome of pregr 1 Live birth 4 Pregnant at time of dec	2 Fetal death 3 Ec	topic pregnancy	23d. Date of del Month	ivery Day Year		
ords, P.O. Box 687.  v requires that the death certification is been signed by the attending should be detached for use as a	by Phys		itions contributing to death but not re	esulting in the underlying cause given i	11 1 40 1 1		e to the cause of death?  Probably 4 Unknown		
cords, Flaw requires has been sign	۷ <del>-</del>					prio priormed? dea	re autopsy findings available r to completion of cause of th? Yes 2 No		
State of the state							Other:		
IVISION or Attendia fler death. Director: /	Certification:	1 Natural 5 Pe 2 Accident In 3 Suicide 6 X Co	rending vestigation vestigation and be vestigation 28e. Place of Injury - At his four four four four four four four four	Fd 1:50 pm 1 Yes nome, farm, street, factory, office building in house	ng, etc. 28f. Location	Street and Number State) 3203 B	or Rural Route Number, City		
Divisior To the Hospital or Attend within 24 hours after death. To the Funcarial Director:			Physician: To the best of my knowled xaminer: On the basis of examination a	dee dooth accurred at the time, date at	nd place, and due to the cau	se(s) and manner a	s stated. e to the cause(s)		
To th within To th	Medical	29b. Signature and title of cert	and manner stated.	29c. License nui O.C.M.E	mber		(Month, Day, Year)		
lacksquare	1		son who completed cause of death (Iten MD Assistant Medical Example 1)	m 23a)					
	State								
Rea	jistra	ד אוחר ד	U LUUS BRUCE	14. 14.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Year Month 1:08 AM **Physician** BARTYNSKI 2009 TUNE EDWARD /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BAYVIEW MEDICAL CENTER BALTIMORE JOHNS HOPKINS Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 1 X M 2 □ F MARYLAND PR5,1930 Director 213-28-8703 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County in than "natural", or Items 23a or 28a-f show the Modical Examinating the notified at 1 ☐ Yes 2 No BALTIMORE DUNDALK Completed by Funeral Director MD. Pages 1 and 2 should be filed within 72 hours after death with the I nent of Health and Mental Hygiene.
Int: If item 27 Is marked other than "natural", or Items 23a or 28a.
Inty or other traumatic event, Itw Modical Examinating Fuel Little 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21222 13 VISTA MOBILE DRIVE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status types 2 ☐ If Yes, Give Year or Dates: 2 No 1 □ Never Married 2 □ Married 1 □Yes 2 □No Specify: WHITE Specify: Baltimore, Maryland 21215-0036 3√∑ Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRINTING PROOF READER 18. Mother's Name (First, Middle, Maiden Surname) (UNK) 17. Father's Name (First, Middle, Last) STANISLAUS BARTYNSKI REGINA 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) DUNDALK, MARYLAND 21222 7555 IVES LANE BARTYNSKI (SON) STANLEY J. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. ST.STANISLAUS CEM.6-11-2009BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility KACZOROWSKI FUNERAL HOME, PA 21. Signature of Funeral Service Licensee 1201 DUNDALK AVENUE BALTIMORE, MD. Robe 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DAY RESPIRATORY Physician /Medical Due to (or as a consequence of): **Examiner** ASPIRATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physiclan: The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical attending pl IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) 2 No □Yes 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed Yes 2 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 2 No Hospital 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 Tes After this Medical Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No M within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide determined 4 Homicide within 24 hours a To the Funeral L Hospital Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVENUE BALTIMORE, MD

State Registrar JOYCE KOH

M.D

park

FASTERN

Régistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2009 12:55A.<sup>™</sup> **Physician** Balakier June Edward Albert /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Gilchrist Care Center Towson 8. Date of Birth (Month, Day, Year) Jan3, 1930 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 X M 2 □ F Maryland 216-24-2282 79 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, If a Modical Expression resist by rodified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ∐Yes 2 K No Director Bel Air Md. Harford 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21015 711 Burnside Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status ty∏Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 2 No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🗓 No Specify þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Goetz & Westvace 12th <u>Truck Driver</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Josephine Krolicki Walter Balakier ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 711 Burnside Drive Bel Air, Md. 21015 / wife Florence Balakier 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Sacred Heart of Jesus 6-13-2009 4□Donation 5 □Other Enction bment 22. Name and Address of Facil Kaczorowski Funeral Home, P. A. 21. Signature of Funeral Service Licensee 1201 Dundalk Avenue Baltimore, Md. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Du to (or as a consequence of): MONTHS **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Physician/Medical attending ph for use as the asn IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. s been signed by the should be detached 9 | Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? ROSCIEROSIS 24a. Was an as l autopsy , page performed' 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate completely filled in by the funeral director, pag ARDIOMYOPATHY 1 ☐Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide TEX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific JUNE 8, 2009

State Registrar 555 W TOWSONTOWN BRUD

TOW. ON, MD 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dominman.

JUN 1 0 2909

31. Date filed (Month, Day, Year)

MO

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** CSONDES LOIS ANN 2000 :00 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Franklin Square Baltimore Dital Rosedale Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Social Security Number . Age (In yrs. last birthday) **Funeral** Months Hours 1 □ M 2X F 68 VIRGINIA MAY 1 1941 Director 220-36-8364 Usual Residence of Decedent 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 1 ☐ Yes 2 XNo BALTIMORE RASPEBURG MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5744 UTRCHT ROAD 21206 U.S.A. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2√2 No Specify: WHITE ģ 3 □Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be CHARLIE BAKER **EVELYN** (SMELSER) 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5766 UTRECHT ROAD BALTIMORE, MD 21206 DANA NEILL/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-10-09 PARKWOOD CEMETERY PARKVILLE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, MD 21237 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final ulmonari **Physician** /Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a consuluence Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) physician a Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: nse yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day 5 Other (specify) the a 9 Unknown 9 Unknown s been signed by the should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an has le 2 s autopsy 1 ☐ Yes 2 No this certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ▼Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To Director: After that in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours aft

To the Funeral DI

completely filled in 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

State Registrar 30. Name and address of person with

th, Day, Year)
JUN 10

DHMH 17 Rev 1/2001

Denus S. farls

9000 Franklin Square Drive, Baltimore, MD 21237

mpleted cause of death (Item 23a) (Type, Print)

		For State Registrar	State of	f Maryland		artmen rtificat		ealth and N Death		giene 2	009	18528
		Decedent's Name (First, Middle, L.)	ast)						2. Date of Dea	ath		3. Time of Death
Physicia		7	ACHARY	TAYLOR	CAR	PER.	.TR.		June	3, 2	Year 1009	2:52 P M
/Medic Examin		4a. Facility Name (If not institution, g			Oziii			Location of Death	-1		inty of Death	~
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Funeral		Social Security Number     6.	Sex	7. Age (In yrs. las			1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 06/16	h v. Year)	9. Birth	nplace (State or Foreign untry)
Director		215-22-4621	1 <b>2</b> M 2□ F	82	Yrs.	IVIOTITIO	Dayo	Tiodic IVIIII	06/16	/1926	Kei	ntucky
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leath atter	ciar	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No		birth 2☐ Fetal on nant at time of de		☐ Ectopic   ☐ Other (s		4			Month	Day Year
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		(Check only 2 Medical Ex	Physician: To the kaminer: On the b	asis of examinati								
o the ithin 2 on the omple	Medical	one)  29b. Signature and title of certifier	and man	ner stated.	1	29	c. Licens	e number		29d. Date si	igned (Mont	h, Day, Year)
FSFO		N/I/m	i 11/1	12			6	3150	-1	Tue	no L	1.2009
		30. Name and address of person w	no completed caus	se of death (Item	<del>28a)</del> (Type,	Print)	.\	~ , ) ]	2 2	21		1 1101
		KUSSELL &	, De Li	ncg, h.	7.3	05	Hos	pital	Drivo	, de	187 M	my My. 6106
Sta		31. Date filed (Month, Day, Year)		Registrar's Signatu	ure	Kel		0	-			
Registra	ar	JUN 1 0 20	UT KEN	wa p.	gea	Jean.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 8, 2009 10:05 PM June Ruth A. Cooke /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Keswick Multi Care Center Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 19,1919 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 M X XF Maryland 220-07-5686 90 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State r 28a-f show notified at 10b. County 1 ☐ Yes 🏋 🕅 No Director Woodlawn MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number and 2 should be filed within 72 hours after death with I teath and Mental Hygiene. m 27 is marked other than "natural", or items 23a or 2 ns 23a or 2 must be n U.S.A. 21207 6428 Dogwood Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Æ Ki No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) other than "natural", or items is Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes X2X No Specify: Specify: White Completed by XWidowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wheeler John Rolfes ၉ traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14 Blue Sky Dr. Owings Mills, MD 21117 Pat A. Allison / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)

Lorraine Park 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of He
Important: If Iten
any Injury or oth
once. XX Burial 2 Cremation 3 Removal from State 6/12/09 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 21. Signature of Jun al Serve License 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. year Immediate Cause (Final Brensl **Physician** metASTAtic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner certificate be executed burial-tran and Due to (or as a consequence of): physician sthe burial Physician/Medical attending p for use as use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) 4□Pregnant at time of death signed by the a P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed Were autopsy findings available prior to completion of cause of death?
 □ Yes 2 □ No 24a. Was an autopsy performed2 Yes 2 No page certificate Physician: 25. Was case referred to medical examiner? director, 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 2 After this funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: or Attending Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No s after death. investigation 2 Accident death the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier June 9, 2009 , vis 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St. Bolto. und Zczox 6701

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day CAMPBELL Month Year **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BUN 8t coups MO 2120-HOSPITAL BAGIMORE If Under 1 Year | If Under 24 Hrs. | 9. Birthplace (State or Foreign 6. Sex 1 X M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examination must be notified at 1 XYes 2 ☐ No Director more 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Department of Health and Mential Hygiene.
Important: If item 27 is marked other than "natural" with any injury or other traumatic events. 11 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∏Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes 2 No þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) enditioner 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be ည 19b. ailing Address (Street and Number or Rural Route Number, City or To n, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Fiancee 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signatore of Funeral Service Licenses 23a. Part Y. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DISEASE STAGE **Physician** END /Medical Due to (or as a consequence of): Examiner PERTENS HU Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to or as a consequence of): sician and burial-trans Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 SEIZUNGS 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed GEMENTIA 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy perform CVA PREVIUUS 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

executed Box 68760, P.0. Division of Vital Records,

law requires that the death certificate be e Hospital or Attending Physiclan: The I 24 hours after death. e Funeral Director: After this certificate ha completely filled in by the To the I within 2

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

neen

29c. License number

1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BRITIME ME

31. Date filed (Month, Day, Year)

and manner stated.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar	ate of Maryland		rtment of H			iene <sub>eg. No.</sub> 2009	18531
	Physicia	ın	1. Decedent's Name (First, Middle, Last)  Nancy M. Carr	coll				June 6	<sup>h</sup> 5 , Day 2009 ear	3. Time of Death 12:30 Am
	/Medic Examin		4a. Facility Name (If not institution, give stree Lorien at Frankfo	t and number)	g Hm.	4b. City, Town, or Balt	Location of Death		4c. County of Deal	
	Funeral Director		5. Social Security Number 6. Sex 1 M	7. Age (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept •	9. Bir 7,1933 Vi	thplace (State or Foreign buntry) rginia
	σ	-	Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	e Mary 3a-f sh	Director	MD n/a	Bal	ltimo			Y□Yes 2□No		
	3a or 28		10e. Street and Number 5102 Walther Ave.			10f. Zip Code 2121	4	1	0g. Citizen of What Co USA	ountry?
96	be filed within 72 hours after death with the Maryland Hygiene.  d other than "natural", or items 23a or 28a-f show event, It. It click from the rest to a clifted at	y Funeral	1 Never Married 2 Married	Vas Decedent Ever in U.S. vrmed Forces? ☐Yes 2☐No Yes, Give		Vas Decedent of His f Yes, specify Cubar □ Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	e, etc.
21215-0036	- " (0)	Completed by	15. Decedent's Educatio (Specify only highest grade cor	rear or Dates: n mpleted)	16a. Deced	lent's Usual Occupa kind of work done d OO NOT use retired,	uring most of work	ing	16b. Kind of Business	
212	filed within Hygiene. other than "	Somp	Elementary/Secondary (0-12)	College (1-4or 5+)		se's Aid	e		Holly Hil	l Manor
ğ	thould be filed within the Markal Hygiene.  marked other than matic event, Italy	Be	17. Father's Name (First, Middle, Last)  Anderson Jones				18. Mother's Name	<sub>e (First, Middle, I</sub> e Base		
Maryland	should nd Mei marke	ပ္	19a. Informant's Name/Relationship (Type. F	Print) ( 3 15 +	19b. Mailir	ng Address (Street a				Zip Code)
ž	and 2 ealth a m 27 is ner trai	3	Mildred J.Carrol					alto,	Md. 21213	Town State
Baltimore,	permit. Pages 1 and 2 should be Department of Heath and Menta Important: If item 27 is marked any injury or other traumatic edone.	20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Denation 5 Other (Specify)  20b. Place of Disposition (Name of cemelery, crematory or other place)  Arbutus Memorial Pk.  Date  20c. Location - City or Town, State  20c. Location - City or Town, State  20c. Location - City or Town, State  20c. Baltimore, Md.								ce,Md.
Ba	permit Depar Impor any in once.		21 ture of Funeral Service Licensee	7/ Scruce					eral Home	e 21213
	Physician		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call mmediate Cause (Final	uice on each line	Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arr	rest,	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a conseque						
	-6'	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events c	Due to (or as a conseque		at 1000	D			
68760,	ficate be executed physician and s the burial-transit	edical Exa	that initiated events resulting in death) Last	Due to (or as a conseque		MENTI	A			
O. Box 68	ath certi attending for use a	Physician/Med	in the past 12 months?	If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of de g □ Unknown	death 3	☐ Ectopic pregnanc	y		23d. Date of do	elivery Day Year
rds, P.	tuires that the de n signed by the a lid be detached t	þ	Part II. Other significant conditions contrib	uting to death but not result	ting in the u	nderlying cause give	en in Part I.		obacco use contribute 'es 2 ☐ No 3 ☐ F	to the cause of death?  Probably 4 Unknown
Division of Vital Records,	The law requir ate has been si age 2 should b	Completed						24a. Was a autop perfor	sy prior to	autopsy findings available o completion of cause of
Vita	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	ital*		Oth	ar:	th (Check only or		
o	ding Physician: The Inc. After this certificate hit funeral director, page	n: To	27. Man or of Death	1   Inpatient 2   E	R/Outpatie 28b. Time o Injury	nt 3 🗆 DUA	Nursing H		dence 6 □ Other (Sp now injury occurred	pecify)
vision	I or Attendin after death. Director: Aft I in by the fun	Certification: T	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	me, farm, st	M 1□	Yes 2 □ No	28f. Location (S City or Tow	Street and Number or i	Rural Route Number,
ō	To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physici	an: To the best of my know	vledge, dea	th occurred at the til	me, date and place	e, and due to the	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29b. Signature and title of certifier	and manner stated.		29c. Licens	e number		29d. Date signed (Mo	nth, Day, Year)
	2 <		30. Name and address of person who comp	eted cause of death (Item	23a) (Type	Print)	10000	118-0	1.MD	21231.
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ure	AUI MANY	· · · · · ·	AMO	W 1- (1)	11239
	Regist	ar	JUN I U ZUUS	Leneur	D. 1	CUSI				

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0

				Certific	cate of	Death		Reg. No.	
	Physician	1. Decedent's Name (First, Middle, Last) Amy Hannah Comiske					2. Date of D Month June		ear 2:04 pm
	/Medical Examiner	4a Fecility Neme (If not institution, give	street and number)		1	•	, or Location of Dee		
		Potomac Valley Nur	sing Home	la at historia If L	Inder 1 Year	Rockvi		Montgom	7
Ġ	Funeral Director	020 10 7729	7. Age (In yrs. I	Mor	nths Days		Min. 8. Date of B (Month, D	l M	Birthplace (State or Foreign Country)
	pud m	Usuel Residence of Decedent  10a, State 10b, County	10c. City	, Town or Location	)				10d. Inside City Limits
	Many He the	MD Montgome	ry Tak	oma Park					1 ☐ Yes 2 No
	uth with the Marylen 23a or 28a-1 show ust be notitied at rai Director	10e. Street end Number 8008 Greenwood Ave	•		f. Zip Code 20912	·		10g. Citizen of Wha	at Country?
2	items items instru	1 Never Married 2 Married	12. Was Decedent Ever in U, Armed Forces? 1 ☐ Yes 2 D No If Yes, Give	If Yes,	ecedent of I specify Cub es 2000	an, Mexican, I	n? (Specify Yes or N Puerto Rican, etc.)		American Indian, White, etc. White
Ö	"natural", or solical Exami leted by F	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	16a. Decedent's	Usuel Occur	pation		16b. Kind of Busir	
Baltimore, Maryland 21215-0020	c • 44 -	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind o	of work done OT use retire	during most o d)	f working	Medical	
nd 2	= + + =	17. Father's Name (First, Middle, Last)	<u> </u>	inysical	. Inci		s Name (First, Middl	e, Maiden Sumame)	
ylaı		Sidney Herwitz					lece Coher		7-0-4-1
Mar	VI W 20 60	19a. Informant's Name/Relationship (Ty	*					ber, City or Town, St.	
e,	Heeling the the	Roy Comiskey, husb	20b. P	lace of Disposition	(Name of		Date Date	ark, MD 20	
TOT	8 5 = 5	1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)		emetery, cremator, sapeake (			6/9/200	9 Beltsv	ille, MD
Baltii	permit. Pege Department of important: if any injury on pace.	21. Signature of Funeral Service License	M01539					cal & Crem	nation Svcs.
		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death						Approximate Interval Between
	Physician /Medical Examiner		Recoure		prop				Onset and Death
68760,	law requires that the death certificete be executed es been signed by the attending physician end a 2 should be deteched for use es the bunel-trensit npieted by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		r as a consequence					
Box 68	th certificet tending phy or use es th an/Medil	resulting in death) Last	J				-		
P.O.	d by the leteched	Part II. Other significant conditions con	tributing to death but not resu	ulting in the underly	ring cause g	iven in Pert I.		-	ribute to the cause of death?  B Probably 4 Unknown
of Vital Records,	The law requires the sale has been signed page 2 should be of Completed by							es an autopsy formed?	24b. Were autopsy findings available prior to completion of cause of death?
E.	The te h						10	Yes 2LeNo	1 ☐ Yes 2 ☐ No
Vita	slan: entific ector, Be	25. Was case referred to medical examiner?	lospitel:		- lo	hor	of Death (Check only	The same of the sa	
	Hys hys	27. Manner of Deeth 1 Platurel 5 Pending	28e. Date of Injury (Month, Day Year)	ER/Outpatient 30 28b. Time of Injury	28c. Inju	4 Liprium	28d. Describ	sidence 6 Other e how injury occurred	
Division	Attendration of deat deat deat by the iffical	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, fay)			28f. Location	(Street and Number own, State)	r or Rural Route Number,
1	Hospit 24 hour Funer stely fill dical	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	sician: To the best of my kno- ner: On the basis of examina and manner steted.	wledge, death occu tion end/or investig	urred at the t ation, in my	ime, date end opinion, death	place, and due to the occurred at the time	e cause(s) and man e, date and place, an	ner es stated. nd due to the cause(s)
U	within 2 to the comple	29b. Signature and title of certifier	<b>^</b>		29c. Licer	nse number		29d. Date signed	(Month, Day, Year)
		1 Ineu	dling	200	DO	038	262	dyne !	9,2009
		30. Name and address of person who co	CATE	0	eave	In m	Lun Su	(to 339	Rockville
7	State Registrar	31. Date filed (Month, Day, Year)	32: Registrar's Signa		1				
DH	MH 16 Rev 6/95	JUN-1 0 200	y Kenny	gare					

**ORIGINAL** 

Physiciar /Medica Examine

Funeral Director

	Please Type or Pr						-		_	ble.		
	1 - State of State of Registrar	Maryland / Do		ent of H cate of L		ind Me		giene Reg. No	Z U	09	18	533
ı	1. Decedent's Name (First, Middle, Last)					2	2. Date of Dea Month	th Da	av	Year	3. Time	of Death
	Daisy M. Cregger						June	4	-	009	11:0	05 P <sup>M</sup>
	4a. Facility Name (If not institution, give street and number	er)	4b. 0	City, Town, or	Location of	f Death				of Death		
	9718 Holmhurst Road	Age (In yrs. last birth			resda If Under 2	M I Ivo I -		1	Mont	gome		
	1 □ M 2 🖾 E	Mon	nder 1 Year iths Days	Hours	Min.	B. Date of Birth (Month, Day	n , Year 1015	)	Cot	untry)	te or Foreign	
	579–88–3098 Usual Residence of Decedent	93 Y	0.			J	une 16,	1910		VIT	ginia	
	10a. State 10b. County	10c. City, Town	or Location					-	-		10d. Inside	City Limits
9	Maryland Montgomery	Bethesd	2								1 □ Y	es 2⊠No
	10e. Street and Number	Dechesu		f. Zip Code				10g. Ci	itizen of	What Cou	untry?	
1	9718 Holmhurst Road			208	17			IIni	ted	Stat	es	
	11 Marital Status 12. Was Decede		13. Was D	ecedent of Hi	spanic Orig	gin? (Spec	ify Yes or No- ican, etc.)		14. Rad	ce - Amei	rican Indian	1
3	1 Never Married 2 Married 1 Yes 2					, Puerto Ri	ican, etc.)			ck, White	e, etc.	
2	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Date	s:	1 ∐ Ye	s 2.2XINo	Specify:				Specif	y: Wh	nite	
	15. Decedent's Education (Specify only highest grade completed)	16a. [	ecedent's	Usual Occupa	ation	of working	, 1	16b. k	Kind of B	usiness/l	Industry	
	Elementary/Secondary (0-12) College (1-40	or 5+)	life. DO NO	OT use retired	)	or morning	·	_				
	12	_Ho	nemak	er					wn H			
2	17. Father's Name (First, Middle, Last)						First, Middle,			ne)		
	Isaiac Jefferson Turley						n Dill					
	19a. Informant's Name/Relationship (Type. Print)	1	•				Route Numbe					0010
	Dewey L. Cregger/Son						ver Sp					
	20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Sta	20b. Place of I cemetery,	orematory	(Name of or other plac	e) : T	Da 10 nme	, 2009	20c. L	ocation ·	- City or	Town, State	
	4 ☐ Donation 5 ☐ Other (Specify)	Parklawn					-				Mary!	Land
	21. Signature of Funeral Service Licensee	M01548	Rober 300 W	e and Addres t A. Pum est Mont	s of Facility phrey I gomery	unera Avenu	1 Home/R e, Rockv	ockv ille	ville, Mar	Inc. yland	20850	
	23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	sed the death. Do no	t enter the	mode of dyin	g, such as	cardiac or	respiratory ar	rest,			Approxir Interval	Between
	Immediate Cause (Final disease or condition Consider	tive Hear								2 wee	nd Death .ks	
	resulting in death)	as a consequence of									•	
	Sequentially list conditions, b. Hypert	ension									15 ye	ars
	If any, leading to impediate Die to for cause. Enter Underlying	as a consequence of	:									
	Cause (Disease or injury that initiated events resulting in death) Last											
	Due to (or	as a consequence of	):									
	d											
	IF FEMALE:	me of prognoncy										
		h 2 Fetal death		pic pregnancy	У			Ť		ate of del onth	Day	Year
	1   Yes 2 12 No 9   Unknown 9   Unknown 9   Unknown											
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?											
	Renal Insufficiency, Malabsorption, Partial											
	Bowel Resection, Urinary Tract Infection  24a. Was an autopsy performed? death?  24b. Were autopsy findings available prior to completion of cause of death?											
	1   Yes 2 No 1   Yes 2 No											
	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No  26. Place of Death (Check only one)  Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA  Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)											
1	27. Manner of Death 28a. Date of	Injury 28b. Ti	ne of	28c. Injur	4 🗆 Nu		e 5 🔀 Hesio 3d. Describe h				CIIY)	
	1 ☑ Natural 5 ☐ Pending (Month, 2 ☐ Accident investigation		ury M		(? Yes 2 □ N	1						
	3 ☐ Suicide 6 ☐ Could not be 28e. Place of	Injury - At home, farr	n, street, fa	ctory, office		28	3f. Location (S			ber or Ru	ural Route N	lumber,
	4 Homicide determined building,	etc. (Specify)					City or Tou	vn, Sta	(e)			

29a. Certifier
(Check only

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and the of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Mihanan Wo

D32610 June 5, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D. 10215 Fernwood Road, Suite 100, Bethesda, Maryland 20817

State 3 Mate filed (Month, Day,

Thomas McNamara,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month June <sup>Day</sup> 2009 Physician 5, 5:00 A M DANIEL BERNARD CRONIN /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore County Baltimore 1307 Regester Avenue If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex **Funeral** Days Hours 1 ₹M 2 ☐ F Months 218-40-8624 66 Feb 1, 1943 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Baltimore Directo Maryland Baltimore County 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21239 USA 1307 Regester Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Specify: White Baltimore, Maryland 21215-0036 ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Supervisory Analyst College (1-4or 5+) Elementary/Secondary (0-12) Procurement Social Security marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health ann Mental Hy Important: If item 27 is marked othrany injury or other traumatic event Be Elizabeth Grob Bernard Joseph Cronin ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1307 Regester Avenue, Baltimore, Maryland 21239 Barbara H. Cronin (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 XBurial 2 □Cremation 3 □Removal from State 4 □Donation 5 □Other (Specify) Dul. Valley Mem Grdns 6/10/2009 Timonium, Maryland 21. Signatu For Fyrital Septe Legsee Martin D. Lawson MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Seven month Physician Carunoma -ung /Medical Due to (or as a c we equence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter on any ing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and as the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760) attending physician for use as the buria by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Yea 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part It Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 Unknown Completed peen: 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No has page 2 1☐ Yes Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 🔲 Inpatient 1 ☐ Yes this Certification: To 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? after death. 27. Manner of Death To the Hospital or Attending Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c, License number 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Marshall Levine, M.D. 6569 N. Charles Street, #205, Towson, MD 21204 32. Registrar's Signature blewa

parked

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup>,\_ DVORAK Month 2009 ELEANOR **Physician** ANNA June 4:30 ам /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Lutherville College Manor Nursing Home Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Months Hours Min. 1 □ M 2 🛛 F November 22, 1923 Maryland 85 Director 212-20-4650 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State is than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 No Glen Burnie Director Maryland Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21060 7166 Furnace Branch Road Apt. 122 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed by 3 ₩ Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Platt Corporation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rose Α. Gilbert Henry H. Hening item 27 is marke other traumatic ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5 Beech Leaf Court, Baltimore, Maryland 21286 Margaret R. Cronyn (Niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State June 12, 2009 Brooklyn Park, Maryland Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
McCully-Polyniak Funeral Home P.A. 21. Signature of Funeral Service Licensia 237 Fast Patapsco Avenue, Baltimore, Maryland 21225 Approximate Interval Between Onset and Death Port 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final neumnen Physician 10 resulting in death) /Medical Due to (or a la consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician; The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760, Physician/Medical as the ned by the aftending produced for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Ö 9 Unknown ٣. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by "srill of im 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an te has age 2 s performed 2 No 2 No 1 ☐ Yes 1 □ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To Fruitity 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1. Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier

State Registrar 29b. Signature and title of tertifier

31. Date filed (Month, Day,

To the within 2.

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1).25205

6781 N. Chiles St. Balts ind 21204

29d. Date signed (Month, Day, Year)

and manner stated.

Bm(

32. Registrar's Signature

30. Name and address of person who completed cause of d th (Item 23a) (Type, Print)

Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 1:15 P. M Arthur Emmett Duff, Jr. 2009 June 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Anne Arundel Linthicum Tate Hospice House If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 1 X M 2 □ F 65 Maryland 212 44 2614 08/08/1943 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 1 ☐ Yes 2X No Anne Arundel Glen Burnie Marvland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21060 108 Sunset Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐Yes 2 🛣 No If Yes, Give 1 Never Married 2 Married 1 ☐Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) Schriber Auto Parts Salesman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Arthur Emmett Duff, Sr. Mary Ellen McLaughlin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Maryland 21225 Jerry Bloomer / Friend 5708 Phillips Street 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Baltimore, Maryland 06/09/2009 Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signatu 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or a a consequence of Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury oh that initiated events resulting in death) Last Due to (or as a consequence of) yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Year Month Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No 24a Was an autopsy performed? Yes 2 No 1 ☐ Yes 25 Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NOther (Specify) 5 P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner Examine

**Physician** 

/Medical

Examiner

Director

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**Funeral** 

Director

Department of Health and Mental Hygiene, instural, or items 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exemines in until be inclined at any injury or other traumatic event, the Medical Exemines in until proper approach.

Pages 1 and 2 should be filed within 72 hours after

permit.

Maryland 21215-0036

altimore,

P.O. Box 68760,

of Vital Records.

The law requires that the death certificate be executed use as the burial-tran jo ned by the a cate has been signed by page 2 should be detach tor; After this certificate the funeral director, pag or Attending Physician: s after death.

Physician/Medical

Completed by

Be

Medical Certification: To

in by t

filled

within 24 hours a

To the Funeral I

completely filled the Hospital

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

examiner?	
27. Manner of Death	5 □ Pendir

5 Pending investigation 6 ☐ Could not be

determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of 28a. Date of Injury (Month, Day, Year)

Injury

28c. Injury at Work? 1 □Yes 2 □ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a. Certifier (Check only one)

2 Accident

3 ☐ Suicide

4 Homicide

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certified se of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2

			State Registrar			Cer	tificate of L	Death		Reg. No.		
<b>养</b>			Decedent's Name (First, Midd	le, Last)					2. Date of D	eath Day	Year	3. Time of Death
ů.	Physicia		Margaret Simmons Doub				June Month					7:00A <sup>M</sup>
	/Medic Examin	aı i	4a. Facility Name (If not institution		r)		4b. City, Town, or	Location of Dea		-	ounty of Death	
A.	Examin	νı	307 Brightwood				Luthervi	lle		Ba	ltimore	9
	Funerai		5. Social Security Number	6. Sex 7. A	lge (In yrs. last b	oirthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	s. 8. Date of B	irth	9. Birtho	lace (State or Foreign
	Director		213-76-1438	1□ M 2\XF	91	Yrs.	Months Days	Hours Iviii	Feb 11	,1918	Mary	land
- Cur			Usual Residence of Decedent									0d. Inside City Limits
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	a-f s	당	Maryland Balti	more	Luthe	rvil	le			T		1 □Yes 2 No
	or 28 e noi	Sire	10e, Street and Number				10f. Zip Code			10g. Citize	en of What Cour	ntry ?
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	r dea	Funeral Director	11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U.S.	13. V	Was Decedent of H f Yes, specify Cuba	ispanic Origin? an, Mexican, Pu	(Specify Yes of retro Rican, etc.)	10-	Black, White,	
36	within 72 hours after death with the Maryland ene. than "natural" or items 23a or 28a-f show he Medical Examiner must be notified at		1 ☐ Never Married 2 ☐ Ma  3XXWidowed 4 ☐ Divorce	AVE SAVE		1	I□Yes XXNo	Specify:		8	Specify: Wh	nite
21215-0036	hours ural	Completed by		nt's Education		Sa. Deced	ient's Usual Occup	ation		16b. Kind	d of Business/In	dustry
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12	withi ene. than he M	Ĕ	Elementary/Secondary (0-12)	College (1-4o	r 5+)	Hom	nemaker			(	)wn Home	<u> </u>
9	filed Hygi ther	ပိ	17. Father's Name (First, Middle	e, Last)	· · · · · ·			18. Mother's N	ame (First, Mido	lle, Maiden S	Gurname)	
an	d be ental ced c	o Be	James Crook Sim	mons				Mar	ie Ziegl	er		
Maryland	shoul nd Me mark	မ	19a. Informant's Name/Relation	ship (Type. Print)	15	9b. Mailir	ng Address (Street	and Number or	Rural Route Nur	nber, City or	Town, State, Zi	p Code)
$\mathbf{\Sigma}$	nd 2 state and 2 s		James C Doub		Son 6	5417	PrattAve	nue Bal	timore M	larylar	nd 21212	
ē,	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hyglene. If Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition		0.0 00.0	of Dispo	sition (Name of matory or other plac	ce)	Date	20c. Loc	ation - City or T	own, State
E O	Page ent o nt: If ry or		XX Burial 2 Cremation		Rest		en Cemete					, Maryland
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra once.		21 Signature of Funeral Service	e Licensee	1.	22						ral Home Inc
ä	permi Depar Impor any Ir		Jannes 14	chontleu	ARIS						, Maryla	and 21212
			23a. Part1. Enter the disease, shock, or heart failure. Li	or complications that caus st only one cause on each	sed the death. D	o not ent	er the mode of dyin	ng, such as card	liac or respiratory	arrest,		Approximate Interval Between Onset and Death
H	Physician		Immediate Cause (Final disease or condition	$\mathcal{C}$	erebo	201	ascul	ar a	cerd	ent		Origer and Deast
H	/Medical		resulting in death)	a.	as a consequenc							
ē.	Examiner		Sequentially list conditions,	b								
	p #	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	ae a consequenc	DE-OI):						
	ecute and trans	Gam	that initiated events resulting in death) Last	C. Due to (or	as a consequenc	re of)·		<del></del>				
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68760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Medical		d								
	se as	-	IF FEMALE:	23c. If yes, outcome	me of pregnancy	,				. 2	3d. Date of deli	verv
Box	leath ce attendi	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth	n 2 ☐ Fetal death	ath 3L	□Ectopic pregnanc □ Other (specify) _	у		_	Month	Day Year
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Δ.	res that t signed by be detac		Part II. Other significant cond	itions contributing to deat	h but not resultin	g in the u	ınderlying cause gir	ven in Part I.	23e. D	id tobacco us	se contribute to	the cause of death?
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or Vital Records,	Attending Physician: r death. ector: After this certific by the funeral director,	5	27. Manner of Death	28a. Date of	Injury 28	Bb. Time of				be how injury		,,,,
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Ö	al or A after I Dire	Certification:	4 ☐ Homicide	building	, etc. (Specify)				0.0, 0.	rom, otato,	,	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1. Certif	ying Physician: To the beat	est of my knowle	edge, dea	th occurred at the to	time, date and p	lace, and due to	the cause(s) me, date and	and manner as place, and due	stated. to the cause(s)
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	St Regist	ate rar	JUN 1 0	2009 Sens	gistrar's Signature	par	Kal					

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

10a. State

Funeral

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23a.

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician/Medical Examiner as the burial-transi Completed by has To the Hospital or Attending Physician: Be မ funeral Certification: within 24 hours after community to the Funeral Director; Aftermore and the funeral Director; After funeral After f

Division or Vital Records, P.O. Box 68760,

JOHN V. THU	CHORX	200 E. Padonia Rd.	Timonium,	11D 2109	)	_ L .
Part1 Enter the disease, or o	complications that caused the death.	Do not enter the mode of dying, such as ca	ardiac or respiratory arrest,		Approximate Interval Bety Onset and	ween Death
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EMALE: Was decedent pregnant in the past 12 months?  1  Yes 2 Who	23c. If yes, outcome pf pregnand 1 □Live birth 2 □Fetal of 4 □Pregnant at time of deal 9 □Unknown	eath 3 ☐Ectopic pregnancy		23d. Date of deli Month		Year

Sequif any cause Cause that is resulted. IF FE 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ★ Yes 2 □ No 24a. Was an 2∐No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 npatient 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one)

and manner stated 29b. Signature and title of certifie Winter

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29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AVE BALTIMORE MODIZIZZ9 900CATON MICH AEL 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** June 2003 3: 12 AM 6 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 65 Hospital Baltsmore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 1 M 2 F Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is invited Event in a roust by notified at once. 1 Yes 2 No Director more 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 21215-0036 1 □Yes 2 No 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Son, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility

JOSEPH RUSS 21. Signature of Funeral Service Licenses ineralin 23a. Part | Enter the divides, or complications that cause that eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shired, or heart filture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1 day Hypercapnic

Due to or as a consequence of): **Physician** Respiratory /Medical Examiner vere Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examiner b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
b Funeral Director: After this certificate has been signed by the attending physician and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) ed by the detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1-Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☑No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier mo KEZ-000 Ariunanjon 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sina Hosp, tal anyon 32. Registrar's Signature 31. Date filed (Month, Day, Year)

ORIGINAL

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-04463 State of Maryland / Department of Health and Mental Hygiene John Nathan Eagle Certificate of Death 1- For State Rea. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day June 4, 2009 1526 hrs John Nathan Eagle Jr. **Medical Examiner** c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Harford 1011 Main Street Apt C 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex Funeral Min. Months Days Hours 213-25-1806 07/05/1989 Country)Maryland Director 19 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County 1 Yes 2 X No Fallston 28a-f show Harford Maryland death with the Maryland Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number notified at United States 21047 1011 Main St., Apt. C 14 Race - American Indian, Black, 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-Funeral 11. Marital Status 12. Was Decedent Ever in U.S. other than "natural", or items the Medical Examiner must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' 1 X Never Married 2 Married Yes 2 X No Specify: white Yes 2 X No specify: Pages I and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. If Yes, Give Year 3 Widowed Divorced þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) n/a not employed Baltimore, MD 21215-0036 9 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sherry Mentzer John Nathan Eagle Sr. t: If item 27 is marked other traumatic event, Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21047 Fallston, MD P. O. Box 562 Sherry Eagle/mother 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State Baltimore, Maryland June 10,2009 Green Mount Crematory Department of Important: Donation 5 Other Specify John O. Mitchell IV, Funeral Services of Dulaney Vall 200 E. Padonia Rd. Timonium, MD 21093 21. Signature of Funeral Service Licensee art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva Physician Between Onset and failure. List only one cause on each line Death /Medical Heroin and clonazepam intoxication Immediate Cause (Final disease taminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and #1 as noted, 23a,27,28a-f,perME, g893 7/22/09 TI Physician/Medical X UNPENDED XAMENDED attending physician for use as the burial -The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? ✓ Yes 2 No Yes 2 certificate te Hospital or Attending Physician: The nate hours after death.

The Funeral Director: After this certifical letely filled in by the funeral director, pa 26 Place of Death (Check only one) 25. Was case referred to medical Be Other<sub>4</sub> examiner? Hospital: 1 Residence 6 V Other: Scene DOA Nursing Home 5 ER/Outpatient 3 Inpatient 2 1 🗸 Yes 28d. Describe how injury occurred 28a, Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 1 Yes 2 X No Natural Pending Fd 6/4/09 Fd 3:18 pm 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1011 Main St. Apt C 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 6 X Could not be Suicide residence determined Fallston, Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2. and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie **OCME** June 5, 2009 O.C.M.E. Name and address of person who complete 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Theodore M. King, Jr., MD. 31. Date filed (Month) Registrar's Signa State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day onth **Physician** /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death Examiner andallstown MOVE ason 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9.27.4 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min. M 2□F Months Hours 65 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County 7 Is marked other than "naturai", or items 23a or 28a-f show traumatic event, the Medical Experience and the modified #1 1 Yes 2 □ No andallstown Funeral Director more 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number スルろろ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces?.

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Executane. 9029. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify Black ð 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) perator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State 21. Signal of Funeral Service Licensee MIZIZIG Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on use a line. Immediate Cause (Final disease or condition resulting in death) **Physician** Inn /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached it 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the upderlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 □ No 1 □Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence Other (Specify) HUSPIL Hospital: 1 Yes 2 000 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 24 hours after death Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide Hospital Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 2.

State

DHMH 17 Rev 1/2001

Registrar

29b. Signature and title of certifier

30. Name and address of person

31. Date filed (Month; Day,

of death (Item 23a) (Type, Print)

29c. License numbe

29d. Pate signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #17,18&19a&b Per Ana Bd G895 9/14/09 JH

Amend Items 41,23e,24a,5 Department of Health and Mental Hygiene 09 dhb, np | 85 4 2

Certificate of Death

Reg. No. 1 - For State Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 5 0215 16 2009 Francell /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Randallstown Genesis Health Baltmore Kandallstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Year) 10 M 2□ F 59 215-60-3658 Yrs. Director Mary Tand Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location 27 is marked other then "naturel", or Itams 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Baltimore 1 ☐ Yes 2√☐ No Director MD Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9109 Liberty Road 21133 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 20 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. 2 should be filed within 72 hours after of and Mental Hygiene.
Is marked other then "naturel", or Itar 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 delivery person cut rate liquors 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) -unk-Be Avery McDuffy Lillian Chester 2 19a. Informant's Name/Relationship (Type, Print) Vonetta, White/daughter Robert Morgan/friend 19b Mailing Address (Street and Number or Bural Boute Number, City or Town, State Zip Code)
3.0 Kintore Court Parkville, Md 21234
6608 Marriott Drive Baltimore, MD 21296 Pages 1 and 2 s ment of Health an ent: If Item 27 Is Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Importent: If eny injury of once. `4 □Donation 5 NOther (Specify) in state 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Dixector 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate terval Between Onset and Death Immediaté Cause (Final **Physician** Carcinoma pladaer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 □ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 21 No 1 ☐ Yes 2X No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred Certification; Hospitel or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. М 2 Accident Director; 6 ☐ Could not be 3 🗀 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours at To the Funerel D Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Descripting Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and decrease stated. 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier R14468Z 5-19-2009 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) Kathy Dai, CRNP, 25 Main Street, Suite 200, Reisterstown, MD 21136

State Registrar 31. Date fifed (Month, Day, Year)

JUN 1 0 2009

27430

25,26

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 3:15a Elaine Gray Jun 2, 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Baltimore Manor Care Health Services 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year | If Under 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Min. Hours Months Days 1 M 2 F Maryland Aug 27, 1927 **Director** 217-24-0990 81 Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it — Medical Evantment rust be muithed at 10a. State 1 X Yes 2 □ No Director **Baltimore** Maryland n/a 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21217 U.S.A 1548 Argyle Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Y Year or Dates: Specify. þ Black 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Miller Brothers Packaging Clerk 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Josephine Stewart Daniel Stewart 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1548 Argyle Avenue Baltimore, Maryland 21217 Lisa Walker 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Catonsville, Maryland 06/09/09 Metro Crematory, Inc. 21. Signature of Funeral Service License 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part i. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** 2nEINER /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760, physician the burial Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year Month Day signed by the atte 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has I irector, page 2 s autopsy performed? Yes 2 2 00 1 ☐ Yes 2 No 1 🗆 Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes Medical Certification: To s after death.

I Director: After this
of in by the funeral d 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide n 24 hours af e Funeral Di etely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou

To the Fune

completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D005910+ D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STONEY SPRING RAZTIMORE mp 21210 DRIVE 2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** KATHERINE GREEN 1:30 PM Μ. 2009 JUNE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HARFORD BEL AIR 1301 E SHERIDAN PLACE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4 – 29 – 1946 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Days Min Months 1 □ M 2 😾 F 63 Yrs. 218-44-5224 MARYLAND Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b County 10a State 1 □Yes 2 No BEL AIR HARFORD Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21014 U.S.A. 1301 E SHERIDAN PLACE Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify: Specify: WHITE þ 3 ☐ Widowed 🎖 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MANAGER STORE 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (ELGERT) Ε. ELLEN JOSEPH I. SKARDA, SR. ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21114 2510 AMBLING CIRCLE CROFTON, MD KEITH GREEN/SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6-9-09 CATONSVILLE, MD METRO CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licenses 21237 ROSEDALE, MD 211 CHESACO AVE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) nsequence Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ₽ 2 No 3 Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 🗆 Nursing Home 5 🏋 Residence 6 🗆 Other (Specify) 1 Yes 2 No Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 2 Accident

or Attending Physician; The law requires that the death certificate be executed ending physician and use as the burial-tran Division of Vital Records, P.O. Box 68760, attending p sate has been signed by the page 2 should be detached certificate funeral director, After this s after death.

I Director: Ai
d in by the fur within 24 hours after
To the Funeral Direcompletely filled in b

Physician

/Medical

Examiner

**Funeral** 

Director

28a-f show

?7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Madical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "..." any injury or other traumadia.

investigation 6 ☐ Could not be determined

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

29b. Signature and

and manner stated

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed, (Month, Day, Year) 29c. License number # 40582

30. Name and address of person who completed cause of death (Item 23a) (Type Print) a 7 0 ld Emmos for Rd Bli Air Md 21015

State Registrar

Medical

31. Date filed (Month, Day, Year)

Registrar's Signature

To the Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ARTHUR **Physician** GARMAN LAMUTTE 2009 30 M UNE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Carroll Hospital Center Westminster If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Day Year) April 9, 1926 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Country) land Months Days Hours 213-20-8751 11⁄2 M 2 □ F 83 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show 10a, State 10b. County d other than "natural", or items 23a or 28a-f sho event, the Medical Examirat must be multified at 1 ☐ Yes 2 🖾 No Director Md. Baltimore Reisterstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number filed within 72 hours after death with U.S.A. 21136 602 Earlton Court Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: White \$ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Laundry and Cleaners Owner permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien. Important: If item 27 is marked other the any Injury or other traumatic event, Item 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carrie M. Byerly George S. Garman ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 602 Earlton Ct., Reisterstown, Md. 21136 Diane M. Garman - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ABurial 2 Cremation 3 Removal from State St. Pauls Cemetery June 12, 2009 Arcadia, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Eckhardt Funeral Chapel, P.A. 211
11605 Reisterstown Rd., Owings Mills. Md.
Approximate 21. Signature of un ral Service Licenses 21117 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) neumonia Physician day /Medical Due to (or as a consequence of): Examiner ) isease Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate be executed and Due to (or as a consequence of) burialphysician Physician/Medical the the attending 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Month Vear for in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

P.0. Division of Vital Records,

Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

e Funeral I

within 2

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

ABJALLAH J. HELOU, M.D.

Doo 17695

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Heloy M.D.

CARROLL HOSPITAL CENTER, WESTMINSTER, MD 21157

31. Date filed (Month, Day, Year) 32. Registrar's Sig ature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month PM **Physician** Charles Edward Garman 8 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Westminster Carroll Carroll Hospital Center If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Pennsylvania 8. Date of Birth (Month, Day, Year) Oct. 29, 1923 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 85 Yrs. Days Hours Min. Months 219-18-4954 1 ☑ M 2 □ F Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 □ No Director Md. Carroll Westminster 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21158 U.S.A. 1000 Weller Circle Unit 115 Funera 12. Was Decedent Ever in U.S.
Amed Forces?
1 ∯Yes, S□No WW II
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Lumber Co. Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Georeg S. Garman Carrie M. Byerly ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ann S. Garman - Wife 1000 Weller Circle #115, Westminster, Md. 21158 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 14 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Pauls Cemetery June 12, 2009 Arcadia, Md. 21. Signature of Funera Service License 22. Name and Address of Facility Lokhardt Funeral Chapel, P.A. 21117 Reisterstown Rd., Owings Mills, Md. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. RESPIRATORY FAILURE Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): PNEHMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HEART FAILURE 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) 2 XVI Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nopatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death

1 Natural

2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

The law requires that the death certificate be executed Box 68760. P.0. Records,

and burial-tran attending physician the ò signed by the ad be detached f page 2 should has certificate this

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modeal Examiner must be notified at

72 hours after death with

filed within 7 I Hygiene.

2 should be filed whand Mental Hygiel

permit. Pages 1 and 2 sl
Department of Health an
Important: If item 27 is i

**Physician** /Medical

Examiner

Baltimore, Maryland 21215-0036

of Vital To the Funeral Director: After th completely filled in by the funeral. Division To the Hospital or Attending death. after death 24 hours within 24 h

31. Date filed (Month, Day, Year) State

Registrar DHMH 17 Rev 1/2001

Medical

4 Homicide

29b. Signature and title of certifier

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANCIS KHOO, M) ZOO MEMORIAL AVENUE, WESTMINSTER, FANCIS KHOO, MI)



and manner stated.

**ORIGINAL** 

1 rifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D 30263

29d. Date signed (Month, Day, Year)

6-8-00

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND #1 Per PHY G892 6/19/09 JH

AMEND #1 Per State of Maryland / Department of Health and Mental Hygiene 0 0 9 For State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Time of Death Day **Physician** 7:28 AM Gilpatrick 2009 J<del>ean Lois Gilpatric</del>k Jean Witman June /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Suburban Hospital Montgomery Rethesda If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Year. Days Hours Min. Months 1 □ M 2 X F 84 NJ 04/05/1925 Director 358-26-7169 Usual Residence of Decedent 10d. Inside City Limits 10b County 10c. City. Town or Location 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, Item the death and 1 ☐ Yes 2 🗷 No Director Potomac MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20854-11215 Seven Locks Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Caucasian 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Unitarian d 2 should be filed within 73 th and Mental Hygiene.
7 is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) Universalist Church Minister 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Jeanetta Nietman William Uhler Witman ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 and 2 s Health ar permit. Pages 1 and Department of Health Important: If item 27, any injury or other tra once. 11204 Old Post Road Potomac, MD 20854-Diana Gilpatrick/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition June 8, 1 ☐ Burial 2 N Cremation 3 ☐ Removal from State Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2009 21. Signature of Funeral Service Ucensee 22. Name and Address of Facility Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician YEARS ARTERIOSELEROTE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dusito (or as a consequence of,: cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran be execu Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 100 3 Probably 4 Unknown ADUANCED 1 🗆 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HOPERLIPIDEMI autopsy performe certificate I 1 ☐ Yes 2 ☐ No 2 🗆 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2≝No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manger of Death To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Mont)

Silpatrick, Jean

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 - For State Registrar

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 230 P M **Physician** Patricia Ann Hudson 2009 JUNE 02 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Cty

| Funder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 20, 1938 Sinai Hospital of Baltimone n/a 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2X F 217-34-5939 70 Maryland Director Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2XX No Director Baltimore Lutherville Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 21093 United States 214 Meadowvale Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 and Mental Hygiene. is marked other than College (1-4or 5+) secretary/clerical Baltimore County Govt. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Harrison Smith Blanche Barth ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other tran 8966 Glenwood Ct. Denton, MD Cheryl Hudson-Largent/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Pages 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Green Mount Crematory June 5,2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee John O. Mitchell V, Funeral Services of Dulaney Valley John O. Mitchell 200 E. Padonia Rd. Timonium, MD 21093 Approximate Interval Between Onset and Death 23a. art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Anoxic encentalizating /Medical Due to (or as a consequence o): Examiner Charic Repinatory Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed Atrial Fibrillation attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Cononary antery IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 □Yes 2 ■No Day Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 No 24a. Was an autopsy Hospital or Attending Physician: The 24 hours after death.
Funeral Director: After this certificate h 1 □Yes 2 No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Tes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title on certifier 29c. License number 163282 lero MID 02,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C. Valeno MD 2401 W. Belvedere Ave. BAHO, MD nai 31. Date filed (Month, Day, Year) Registrar's Signature State JUN 1 0 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

State of Maryland / Deportment of Health and Mental Hygiene? [] [] 9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 6:00 A NANCY LOUISE HICKEN 2009 June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore <u>Greater Baltimore Medical Center</u> Towson
If Under 1 Year Birthplace (State or Foreign Country) Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MAR 25,1933 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1□M av Maryland 215-30-1247 76 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the "hedgest Examiner must be notified at 1 ☐ Yes 2 🙀 🕅 Director Baltimore Timonium Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2205 Eastlake Road 21093 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 🗞 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 1 Never Married 2 Married 1 □Yes 2 XXIVo White If Yes, Give Year or Dates: Specify þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, I'll. Man Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothea Louise Ernst Henry Pasterfield Hardin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2205 Eastlake Road Timonium Maryland 21093 William Joseph Hicken Hus Baltimore, Date 20c. Location - City or Town, State 20a. Method of Disposition

1 ☐ Burial 2 🛱 ★remation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other, (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) GreenMount Crematory June 10,2009 Baltimore, Maryland 22. Name and Address of FaMt TCHELL-WIEDEFELD FUNERAL HOME INC Strature of Funeral Society Licenson MMOX 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 3day **Physician** meumoni /Medical Due to (Ar as a consequence of): Examiner Sequentially list conditions, if any, leading to initial data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner executed and burial-tra Due to (or as a consequence of): the attending physician the dor use as the buria P.O. Box 68760 requires that the death certificate be Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 3 Ectopic pregnancy Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 ☐Yes 2 ☐No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this o completely filled in by the funeral dire 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DCA 2 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

**JUN 1**0

F. Wheaton Mic

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 1 2 Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Ye ar 2009 5:45 PM 06 Ellen R. Jones 02 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death White Marsh, Maryland
If Under 1 Year | If Under 24 Hrs. | 8. Date of Bi Baltimore 11201 Beach Road 8. Date of Birth (Month, Day, Year) 04/17/1923 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Hours Min 1 ☐ M 2 🕱 F 86 Iowa 478-24-2544 Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location 1 ☐ Yes 2 X No MD Baltimore White Marsh 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number U.S.A. 11202 Beach Road 21162 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2**X** No Specify: Specify: 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed 12 Musician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Agnes Bro Lars Ringsborg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11201 Beach Road - White Marsh, Maryland 211
se of Disposition (Name of Date 20c. Location - City or Town, State 21162 Niles R. Jones (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem. 06/05/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. C. 11750 Belair Road - Kingsville, Maryland assakn 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) -VA (Stroke Due to (or as a consequence of): ardionyupat Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a convequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 10 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 XNO 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other Injury at 28d. Describe how injury occurred son's Hospital: 1 ☐ Yes 2 ER/Outpatient 3 DOA 1 Inpatient 6 X Other (Specify) residence 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 □Yes 2 □ No 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

and attending physician nse for the signed by director, page 2 should has or Attending Physician: The this certificate hours after deat meral Director: filled in by the า 24 hours a

**Physician** 

/Medical

Director

Funeral

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Completed

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Examiner

Physician/Medical

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Completed

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Certification: To

Medical

**Examiner** 

**Funeral** 

Director

ed other than "natural", or items 23a or 28a-f show event, the Medical Experience frust be rediffed at

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

I Hygiene.

Department of Health and Mental Important: If item 27 is marked o any injury or other traumatic eve once.

**Physician** 

/Medical

**Examiner** 

Maryland 21215-0036

Baltimore,

To the I within 2 To the I

State Registrar

P ---

29a. Certifier

(Check only

29b. Signature and

30. Name and address of person who complete 32 A istrar's Signature

and manner stated.

cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amendate of Waryland Department of Health and Mental Hygiene? Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 9:15A **Physician** June3,2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Boula mor in If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1□M 2**X**F 80 Yrs. 214 - 25 - 5580 Usual Residence of Decedent **Director** 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28a-f show Department of Health and Mental Hygiene. Important: If item 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the live fice it and in an institution of the content of the live fice it and institution of the content of the live fice it and its first of the content of the live fice it and its first of the content of the live first of the li 1 Yes 2 □ No **Funeral Director** BAITIMORE MiD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4.5.A Bouldin 2/205 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: ò ACK 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) BAITIMENT Elementary/Secondary (0-12) College (1-4or 5+) Public Shehos NONE GRAD C 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LEASE WARREN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1100 Alexander AVE BATTIMORE , MARY/And 215 herre Hunter 20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest Cem. 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 ■ Gremation 3 □ Removal from State Owings Mills 6-12-09 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Home BETTS FUNERA) HOME 1129N. CAROline ST. BALTO. MD. 21213 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Myocardea **Physician** /Medical Due to r as a consequence of): **Examiner** Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed OVENOVO Physician/Medical IF FEMALE 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) 1 □ Yes 2 ☑No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Pasidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 ☐ Pending investigation 1 □Yes 2 □No within 24 hours after death.

To the Funeral Director; / 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 
Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 \ Homicide Medical ( Lactifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Oryans 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** Robin Elaine Kunschman 7:55 A.<sup>™</sup> June 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 414 Orchard Avenue Anne Arundel Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/25/1965 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months 1 □ M 2 X F 43 Montana 220 90:7979 Director Usual Residence of Decedent ould be filed within 72 hours after death with the Maryland Mental Hygiene. 10d Inside City Limits 10c. City, Town or Location 10a. State ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Baltimore Anne Arundel Marvland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21225 414 Orchard Avenue Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2X Married 2**√** No Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed by White 3 Widowed 4 Divorced 'natural", 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation the Medical (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Balto. Wash. Med. Cen. Film Librarian 12th other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be n and Mental Ernest Rubright Erma Henry မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Maryland 21227 Health a 2004 Northeast Avenue Craig Kunschman / Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of He
Important: If iten
any Injury or oth
once, 1 ☐ Burial 2 【I Cremation 3 ☐ Removal from State Bayview Crematory 06/08/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each the. Approximate Interval Between Onset and Death Metastati Immediate Cause (Final anow 4.5 Years **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner death certificate be executed the burial-tran and Due to (or as a consequence of): P.O. Box 68760 physician use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) led by the a detached f 9 Unknown 9 Unknow 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signé I be d Division or Vital Records, þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has N autopsy performed? Yes 2 X No page 1 Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check onl on Be Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ို 1 Inpatient this funeral Manner of Aath 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: or Attending After 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident death. investigation within 24 hours after death To the Funeral Director; completely filled in by the 1 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Hospital X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 39505 Ture 5, 2009 (Item 23a) (Type, Print) 305 Hospital Dr. Glen Burnie, MD 21061 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) dhish can 31. Date filed (Month, Day, Year) JUN 10 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month 0.5 **Physician** Baby Girl Ku 4a. Facility Name (If not invitation, give street and number) Mercy Medical Cen 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltmore ( Baltimor Medical Center If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Funeral 26 Director Usual Residence of Decedent 10c. City, Town or Location death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene.

Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a State 1 Yes 2 No Baltomor Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number nla nla nla Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specity Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Black Saltimore, Maryland 21215-0036 Specify. 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) nove none none 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be NOWN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Parkville, MD Hershema -NOX 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Methed of Disposition 3 Removal from State 1 ☑ Burial 2 ☐ Cremation Baltimore, MIS -31-09 4 □ Donation 5 □ Other (Specify) - ASKHON 21. Signature of Funeral Service 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) ed by the a nla 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an certificate has autopsy performed Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Yes To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this 28b. Time of 28d. Describe how injury occurred Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 🛂 No nla nla 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 □ Could not be 3 Suicide 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cardice Mak, 201 St. Paul Place, Labor + Delivery, Baltmore, MD

DHMH 17 Rev 1/2001

State Registr<u>ar</u> 31. Date filed (Month, Day, Year)

ORIGINAL

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 10:15 am 09 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A JOSEPH RICHEY HOSPICE HOUSE BALTIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 07/29/1917 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Min. 1 □ M 2 🕇 F PA 91 217-03-6513 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, its Medical Examination of the notified at 1 ☐ Yes 2 No Director BALTIMORE PIKESVILLE 10g. Citizen of What Country? 10e. Street and Number 21208 USA 7 SUDBROOK LANE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 'natural", or items 11. Marital Status 1 ☐ Never Married 2 ☐ Married WHITE Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. þ 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) WHOLESALE JEWELRY Elementary/Secondary (0-12) 12 College (1-4or 5+) **BOOKKEEPER** SUPPLY permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygin Important: If item 27 is marked other 1 any Injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) BLUMBERG URIS ANNA UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8116 MCDONOGH ROAD, BALTIMORE, MD 21208 LARRY KOFSKY / SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cometery, crematory or other place 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State FOREST LAWN CEMETERY 06/08/2009 NORFOLK, VA 4 ☐ Donation 5 ☐ Other (Specify) SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 TUCOK 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 1 ☐ Yes 2 No 9 ☐ Unknown Pregnant at time of death 5 Other (specify) signed by the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐Yes 2 ☐No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Dother (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA မ 1 Inpatient HOUDICE 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After 1 Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No ne Hospital or Attendi 24 hours after death. ne Funeral Director: A 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier H0064267 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lurder My Bulhmae, 40. 2120

Registrar

State

Esther Kofsky

31. Date filed (Month, Day, Year)

Worth Brun

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) **Physician** Wanda F. Leuschner June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 116 Hilltop Road If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 💢 F 219-40-4704 66 March 11, Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at N/A MD Baltimore **Funeral Director** 10f. Zip Code 10e. Street and Number 21225 116 Hilltop Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: \$ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, its insonce. Elementary/Secondary (0-12) College (1-4or 5+) Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethel T. Witt Nathaniel H. Russell ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 116 Hilltop Road Baltimore, Maryland 21225 Gustave Leuschner husband Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory June 4, 2009 4 □ Donation 5 □ Other (Specify) 22. Name and Address of FacilityMcCully Polyniak Funeral Home PA 21. Signature of Funeral Service Licensee 237 East Patapsco Ave. Baltimore, MD 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** dann Due to (or as a consequence of): Examine To the Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours after death.

Baltimore, Maryland

3. Time of Death

12:30

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 🏚 No

N/A

Maryland

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

3 Ectopic pregnancy

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

23d. Date of delivery Dav

23e. Did tobacco use contribute to the cause of death?

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

Physician/Medical

ş

Completed

Be

Certification: To

Medical

i Director: id in by the

n 24 hours aft e Funerai Di eteiv filled ir

To the

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown

1 Inpatient

and manner stated.

5 ☐ Other (specify)

24a. Was an autopsy performe

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown

1 ☐ Yes 2 No 26. Place of Death (Check only one)

28d. Describe how injury occurred

Reg. No.

2009

USA

3,

Year

4c. County of Death

10g. Citizen of What Country?

Race - American Indian, Black, White, etc.

Specify: White

16b. Kind of Business/Industry

20c. Location - City or Town, State

1943

24b. Were autopsy findings available prior to completion of cause of death?

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death 1 Natural 2 ☐ Accident

3 Suicide

4 Homicide

5 ☐ Pending investigation

28a. Date of Injury (Month, Day, Year) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA 28b. Time of Injury

Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number

29b. Signature and title of dertifier

36900

06-03-2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N) HWY, GLEN) BURDIE MC 21061 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

P.O. Box 68760.

Division of Vital Records,

ORIGINAL

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** M Marie Lewis 8:54p Jun 6, 2009 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Severn 8630 Pioneer Drive If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1□ M 2□ F Months Director 214-38-5268 May 3, 1921 Maryland Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location id other than "natural", or items 23a or 28a-f show event, the Medical Evanding roust be notified at 1 XYes 2 No Director Anne Arundel Severn Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8630 Pioneer Drive 21144 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ite any Injury or other traumatic event, it a Medical Eventries. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No <u>Ş</u> Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marie Saunders William Saunders ဂ 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8630 Pioneer Drive Severn, Maryland 21144 Martha Wilson Baltimore, 20b Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/12/09 Elkridge, Md. Meadowridge Memorial Park 21. Signature 4 Femeral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 2121 Liga 23a. Part 1. Enter the disease, or complications that caused the death shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, w **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Que to for as a nonsequence offi-Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical as the use If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) cate has been signed by the a page 2 should be detached to ☐Yes 2☐No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2.2000 this certificate 1 ☐ Yes 2 No 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**√**N₀ 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of 0 063726 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEN 406 CXMM ( M W/thos 3. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Certificate of Death

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Reg. No.

1 - For State Registrar Physician /Medica **Examine Funeral** Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland or items 23a or 28a-f show miner must be notified at Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once. Baltimore, Maryland 21215-0036 **Physician** /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal-transit Division of Vital Records, P.O. Box 68760,

JUN 1 0 2009

	1. Decedent's Name (First, Middle, L.	ast)				Date of Death     Month	Day	Voor	3. Time of Death		
1	DEAN	IA JEAN MA	IZ				Year	4.54 am			
	4a. Facility Name (If not institution, gi			4b. City, Town, or Locat	ion of Death	June	4c. County of	f Death			
	The Johns Hopkins I	Hospital		Baltimore Cit	У						
		Sex 7. Age	(In yrs. last birthda	Months Davs Hou	nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day, Ye	ear)	Coun			
	None	1 L M 2 32 F	O Yrs	0 1		06/05/	2009	Ma	ryland .		
	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				1	10d. Inside City Limits		
5		. 1 1	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		d				1 ☐ Yes 2 🗹 No		
מכו	MD Anne  10e. Street and Number	Arundel		Pasac	пепа_	100	a. Citizen of W	hat Coun	ntry?		
rulleral Directo		ı		211	2.2		II	S.A			
פ	209 Lake Road	12. Was Decedent E	ver in U.S.	13. Was Decedent of Hispani If Yes, specify Cuban, Me		ecify Yes or No-	14. Race	- Americ	an Indian,		
	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ N				Hican, etc.)		, White,	etc.		
'n	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑No Spe	ecify:		Specify.	Wh	ite		
Completed	15. Decedent's (Specify only highest g		16a. De	ecedent's Usual Occupation live kind of work done during	most of work		6b. Kind of Bu	siness/In	dustry		
l bie	Elementary/Secondary (0-12)	College (1-4 or 5-		fe. DO NOT use retired)			-	Infa	nt		
5	0	0		Infant	Mother's Nam	e (First, Middle, M			1111		
De	17. Father's Name (First, Middle, Las								110		
0	James Albert		401. 14	lailing Address (Street and N		ia Mari					
	19a. Informant's Name/Relationship			_			MD 21		, 6666)		
	James A. Lenz,	Jr./Fath		Lake Road isposition (Name of			Oc. Location -		own, State		
	1 Purial 2 ☐ Cremation 3		cemetery,	crematory or other place)	!		Glen Burnie, MD				
	4 ☐ Donation 5 ☐ Other (Special Signature of Fundal Service Light		Gren	22. Name and Address of							
	21. Signature of Fune at Service Lice	FIISCE							-		
_	23a. Part 1. Enter the disease, or co	emplications that caused	the death. Do not	169 Riviera	ch as cardiac	or respiratory arre	st,		Approximate		
	shock, or heart failure. List onl								Interval Between Onset and Death		
	disease or condition resulting in death)	a Com	plexc	ongenital	near	+ ais ea	se				
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er	Sequentially list conditions, if any, leading to immediate	b Due to (or as a	a consequence of)	:							
Examine	cause. Enter Underlying Cause (Disease or injury										
	that initiated events resulting in death) Last	Due to (or as	a consequence of)	:							
an/Medical		d	. <u>.</u>		'						
Med	In FEMALE.										
an/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2  Fetal death	3 Ectopic pregnancy			3d. Date of delivery  Month Day Year				
	in the past 12 months? 1 ☐ Yes 2 🔀 No	4 ☐ Pregnant at 9 ☐ Unknown		5 Other (specify)					Month Day Year		
뒫	9 Unknown			Manager and the second second	n Dort I	220 Did tob	acco use con	ribute to	the cause of death?		
2	Part II. Other significant conditions	s contributing to death b	ut not resulting in	the underlying cause given in	II Fait i.	1 \( \text{Yes}			bably 4 Unknown		
ted					<del></del>						
싎						24a. Was an autopsy perform	,	prior to o death?	completion of cause of		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of the conditions contribute to t								2 No			
Be	25. Was case referred to medical examiner?	Hospital:		Other		th (Check only one					
	1 Yes 2 No	28a. Date of Inju		atient 3 DOA 4	. □ Nursing Ho	ome 5 Resider			iry)		
<u>::</u>	27. Manner of Death  1 Natural 5 □ Pending 2 □ Accident investiga	(Month, Day		iury Work?  M 1 Yes	2 □ No	Edd. Bootilbo iii	,,				
cat	3 ☐ Suicide 6 ☐ Could no	t be 28e Place of init	ıry - At home, farm					per or Ru	ıral Route Number,		
27. Manner of Death 1											
ٽ =	29a. Certifier 1 Certifying	Physician: To the best of	of my knowledge,	death occurred at the time, d	late and place	, and due to the ca	ause(s) and m	anner as	stated.		
dica	(check only 2 Medical E. one)	xaminer: On the basis or and manner sta	examination and/	or investigation, in my opinio	on, death occu	urred at the time, d	ate and place	and due	e to the cause(s)		
ē ∑	29b. Signature and title of certifier			· 29c. License nun	nber	29	9d. Date signe	d (Month	, Day, Year)		
	1 College 2	Liches Tris	coll	DE	1533	0	lune	6.	2009		
	30. Name and address of person w			Type, Print)	- )	- 1	, , ,		2002		
	Colleen +	lughes "	Drisco	4 4	600	North Wol	fe St, Ba	ltimo	re, MD, 21287		
_	31. Date filed (Month, Day, Year)	32. Registra	ır's Signature								

DHMH 17 Rev 1/2001

State

Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Amend Items 23e, 24a, b, 25, 26, 21, 29a per dr., g892,06/10/09dhb 1 - State Registrar Reg. No. 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) 11.00 AM **Physician** LEHMAN ELIZABETH 19 2009 05 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Shady Grove Hospital Rockville Montgomery 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Aug 23, If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 □ M 2 🕅 F 1906 102 Director 220-48-5136 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show 10a. State 10b. County Department of Health and Mental Hygiene important: If item 27 is marked other than "natural", or items 23a or 28a-1 show important: If item 27 is marked other than "natural", or items 29a or 28a-1 show injury or other traumatic event, the Medical Examinar mast be notified at once. 1 ☐ Yes 2 ☐ No Director Montgomery Rockville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 9701 Veirs Drive 20850 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: white 2 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) own home homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna E. Oler William C. Wisegarver 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9701 Veirs Drive Rockville, MD Chaplain Robert Day 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Sign ture of Euneral Service Licenses Ade, Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown After this certificate has been signed by funeral director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ₽ anemia, failure to thrive 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 □ No uealii? 1∐Yes 2**X**∏No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2√No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 ho

To the Fune

completely f (Check only and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number lane', Rane' MD 68178 9/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Rockville, MD 20850 Dr. SAntosh Rana 31. Date filed (Month, Day, Year) 32. Fegistrar's Signature State JUN 1 0 2009 Registrar

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25,20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 9 Certificate of Death 2. Date of Death Month 3 Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Elizabeth Marie McCann 2009 5:50a 6 June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Baltimore Parkville Oak Crest Village Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 □ ¥ Days Hours Min Months Yrs 212-44-6927 MD Director Sept 1911 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No Parkville MD Baltimore Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code USA 21234 8830 Walther Blvd. T-115 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐XNo Maryland 21215-0036 white þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) domestic homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Minnie Kathryn Schloeman John Ambrose Miller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10227 Harvest Fields Dr., Woodstock, MD 21163 Margaret Osborne (daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Lorraine Park Cem. 6-10-09 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Pargestaight erbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ASCVD /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Uscase or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-transit death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Year Month for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ్స్ట్ Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Hohknown Dementia Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death Check onl one funeral director. Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 10 <sup>2</sup> this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending investigation 1 Tes 2 🔲 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 6-8-09 R067343 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parkville, MD. 21234 Blvd BNP 8800 WALTHER BRAZICA 31. Date filed (Month, Day, Year) State JUN 1 0 2009 Registrar

P

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year Nancy Jane Strickland Mullins 2009 11:10pm <sup>M</sup> June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Carroll Hospice Dove House Westminster Carroll If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Dec. 20, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2√ F 238-54-9131 98 Dec. **Director** 1910 NC Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evantiner must be notified at Director 1 ☐ Yes 2 ☐ No MD Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6922 Hollenberry Road Funeral 21784 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify: 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Billy Gay Strickland ၉ Emma Wall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rev. Walter Earl Mullins (Son) 6922 Hollenberry Road, Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 6/8/2009 Sykesville, MD 21. Signature of Funeral Service Licensee Address of Facility HOME & CHAPEL HAIGHT Blean MOONLH Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications discaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death 120 RE Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisass of jury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed and as the burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, been signed by the attending physician Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed2 1 □ Yes 2 □ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6-Other (Specity) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death. To the Funeral Director: After this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signatu nd title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who ompleted cause of death (Item 23a) (Type, Print) South Center Street Westminster MP Flavio

Registrar DHMH 17 Rev 1/2001

State

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Glen Burnie Baltimore Washington Medical Center Birthplace (State or Foreign Country) If Under 1 Year Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🔀 F 67 214-40-7257 1942 Maryland February **Director** Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wodleal Evantines must be notified at 1 Yes 2 No MD Pasadena Anne Arundel Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21122 1520 Park Lane Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ∐Yes 2 😿 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: White Specify: 9 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Balto. City Public Works 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anthony Cirelli Anna Bastianelli 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 1520 Park Lane Pasadena, Maryland 21122 Dennis J. McMenamen husband June 09 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State Meadowridge Memorial Park 20Ŏ9 Elkridge MAryland ዙርሮሀባባሃ<sup>A</sup>ዋንባሂቭና Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 21. Signature of Funeral Service Licensee 23a. P. A. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death lron ediate Cause (Final isease or condition resulting in death) **Physician** 4M3dM 900112 /Medical Due to (or as a consequency of): **Examiner** Sequentially list conditions Examiner as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed 1030 Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy
□ Live birth 2 □ Fetal death
□ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month 5 Other (specify) detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed by be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 5 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has page 2 autopsy performed? Yes 2 No 2 10 1 ☐ Yes 1 Tes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be 2 1 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: €R/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient Medical Certification: To this After th funeral . Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 □Yes 2 □No death. 2 Accident within 24 hours after death

To the Funeral Director; completely filled in by the f 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d Date signed (Month, Dav. Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, 32. Registrar's Signature Day, Year) State JUN 1 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 29d per dr., g892,06/10/09dhb Reg. No. 2009 8562 1 - State Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** June 4, 2009 10:40 A<sup>M</sup> Jack Childs Merriman, Sr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson Blakehurst If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 12,1922 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours Months Days Washington DC 1 M 2□ F 87 710-09-7536 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marjoral Examinst Du notified at once. 1 □Yes 2√√No Towson MD Baltimore Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21204 Apt 549 1055 W. Joppa Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 □X'es 2 □ No If Yes, Give Year or Dates: WWII 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify Specify: USA ģ 3 Widowed 4 Divorced Completed 16b Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Legal Attorney at Law 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jeannette Shoul John Thomas Merriman ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Towson, Maryland 21204 1055 W. Joppa Road Apt 549 Marjorie Merriman / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Towson, Maryland Hilltop Serv. Corp. 6/6/09 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Towson, Mar Ruck Towson Funeral Home, 21. Signature of Funeral Service Licensee Maryland 21204 ne, Inc. 1050 York Road Telk 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nuns Immediate Cause (Final ung uncer **Physician** disease or condition resulting in death) /Medical Due to (5) as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐No ed by the 9 Unknown Division of Vital Records, P.O. 9 Unknown signed by 1 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown arter diseas page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 D No The 1 ☐ Yes 2 ☐ No certificate ı∐Yes Physician: funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 1 Natural Injury Hospital or Attending 5 Pending investigation To the Hospitar ... within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

State Registrar

DHMH 17 Rev 1/2001

N CHARLES

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GTSMC

MO

31. Date filed (Month, Day, Year)

6701

32. Registrar's Signature

STREET

BATIMORE MD21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 4:07 A M 06 2009 ERALDINE unp /Medical 4c County of Death acility Name (If not institution, give street a City, Town, or Location of Death **Examiner** RUNde Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Under 2 7. Age (In yrs. last birthday) 1 □ M 2 🕶 F Funeral Hours 09/06/ 89 Yrs Maryland 217-05-8157 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location ortant; If item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the Madical Examinar must be nutfilled at 28a-f shov 1 □Yes 2 No Director Anne Arundel Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21226-2003 U.S.A. 1018 Belvedere Place Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status and 2 should be filed within 72 hours after de. 27 is marked 1.2. Black, White, etc. 1 □Yes 2 ☑No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 ■No Specify: Specify: White à 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ada Schach James Harry Haven ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 of Health 1018 Belvedere Place, Baltimore, MD 21226-2003 Paul A. Meluh / Husband Department of Heal Important: If Item 2 any Injury or other 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Entombment
1 □ Burial 2 □ Cremation 3 □ Removal from State 06/10/09 Loudon Park Cem Baltimore, MD 4 □ Donation 5 ☑ Other (Specify) 22. Name and Address of Facility G.J.Gonce Funeral Home, PA 21. Signature of Fureral Service Icensee 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Ental the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** gastrointestiva disease or condition resulting in death) /Medical ✓ Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed burial-tran the attending physician and ned for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. if yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 □ Yes 2 XNo 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) certificate has been signed by rector, page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 2 100 1 Yes 1 □Yes 25. Was case referred to medical examiner? After this certification, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 □Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D66186 cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed timore washington medical Center, glen Burnie, Manyland Soleyah Groves 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

/Medical June 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death FRANKLIN SQUARE HOSPITAL ROSEDALE 8. Date of Birth (Month, Day, Nov. 2, 1929 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days XX M 2 F 212-43-7957 79 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location rai", or items 23a or 28a-f show Examiner must be notified at Director Maryland Baltimore Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4929 Ridae Rd. 21237 MARTI Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
snt: If Item 27 is marked other than "natural", or ite 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 X Married 21215-0036 1 □Yes 2 🕇 🥎 o 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Flamentary/Secondary (0-12) College (1-4or 5+) N/A Self-Employed Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Henry Martin Anna Elizabeth Bohlen ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4566 Ridge Rd. Baltimore, Maryland 21237 Robin A. Bartenfelder (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages 1 Department of h Important: if ite any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-12-2009 Zion Church Cemetery Signature of Funeral Service Licensee Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Encephalopathy Anoxic Brain Medical Due to (or as a consequence of): Examiner cardiac Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed CysToscop and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ned by the attending physician detached for use as the buria Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown n signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. peen s 24a. Was an has after death. Director: After this certificate 1 ☐Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient filled in by the funeral dir Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 1 Natural 5 Pending investigation 2 Accident

6 Could not be determined

Welker

Welker

of person who completed cause of death (item 23a) (Type, Print)

32. Registrar's Signature

3 🗌 Suicide

29a. Certifier

4 Homicide

(Check only one) 29b. Signature and titl

30. Name and address

James 31. Date filed (Month, Day, Year)

JUN 1 0 20

1. Decedent's Name (First, Middle, Last)

WILLIAM E. MARTIN

**Physician** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

10

within 24 hours a

State Registrar

Medical

DHMH 17 Rev 1/2001

**ORIGINAL** 

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

1 ☐ Yes 2 X No

Maryland

White

5:25P M

Reg. No.

2009

4c. County of Death

USA

Specify:

16b. Kind of Business/Industry

Martin Farm

20c. Location - City or Town, State

Baltimore, Md.

BALTIMORE

14. Race - American Indian, Black, White, etc.

2. Date of Death

Month

Dav

23e. Did tobacco use contribute to the cause of death?

23d. Date of delivery

1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

autopsy performed 2 No

24b. Were autopsy findings available prior to completion of cause of death? 2 □No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year,

4005202L

9000 FRANKLIN SQUARE DR BOLTO IND

		•	1 - For Amend Item Registrar	State of Marylan 21 per fn, g89	2,067107 Certif	nent of He 0 <b>9dhb</b> cate of D	eaith and ivi eath	ептат тус ғ	Reg. No. 2009	18565	
	Physicia	an	1. Decedent's Name (First, Middle, Las	MARSHA	1 1			2. Date of Dea Month	Dav Year	3. Time of Death	
No. of Section	/Medic		4a. Facility Name (If not institution, give			City, Town, or Lo		MAY	25 2009 4c. County of Death		
				SPITAL			TIMORE				
	Funeral Director		217-36-0710	7. Age ( <i>In yrs. I</i> M 2□ F  68			If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day 05/18/1	9. Birth Cou 1941 Mary	place (State or Foreign intry) Land	
	rland <b>ow</b>		Usual Residence of Decedent  10a. State 10b. County	10c. City	y, Town or Location	on				10d. Inside City Limits	
	e Mary Ba-f sh	Director	MD Anne Aru	ndel Bal	Ltimore					1 □Yes 2¥ No	
	h with th	al Dire	10e. Street and Number  103 Walton Avenu	ie	1	0f. Zip Code <b>21225</b>			10g. Citizen of What Cou USA	intry?	
9600	permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tien 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is finded. Evan it at a matter indiffered and once.	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☑ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1		77	panic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)			
21215-0036	ithin 72 he ne. <b>han "natu</b> Medical	Completed	15. Decedent's Edi (Specify only highest grade Elementary/Secondary (0-12)		(Give kind life. DO l	IOT use retired)	ion ring most of worki	ng	16b. Kind of Business/I	1	
Baltimore, Maryland 2 <sup>-</sup>	be filed w ntal Hygie ed other t event, to	Be	9th 17. Father's Name (First, Middle, Last) John Lee M	larshall	Truck	Driver	8. Mother's Name <b>Evelyn</b>		Ship Repa		
aryli	should and Me mark umatic	오	19a. Informant's Name/Relationship (7	Type. Print)	19b. Mailing A	dress (Street an	d Number or Rura	al Route Numbe	er, City or Town, State, Z	ip Code)	
Ž,	and 2 ealth a n 27 Is		Betty Lou Marsha		J		<del>-</del>		e, MD 21225		
ore	ages 1 nt of H : If iter		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		lace of Dispositio emetery, cremato			)ate	20c. Location - City or T		
Ħ	nit. Pa artmei ortant Injury e.		4 □ Donation 5 ♣ Other (Specify  21. Signature of Funeral Service License						Baltimore, al Service,		
m	an ja		Donna Znami	rowski per D		l Ritchi	e Highwa	y, Balt	imore, MD 2	21225	
	Physician	S Y	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	lications that caused the death one cause on each line.					rest,	Approximate Interval Between Onset and Death	
, i	/Medical Examiner		resulting in death)	Due to (or as e consequ	uence of):					I DAY	
		Jer	Cequenitally list conditions, if any, leading to immediate	Due to (or as a consequ	DAGULO uence of):	PAINY	- Victoria		1.70		
	ecuted and transit	Examiner	coquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			DISSEMI	NATED	INTRAV	IASCULAR	DAY	
58760,	tificate be executed ig physician and as the burial-transit		rooming in dominy and	Due to (or as a consequent	uerice or).				OUR G GC/AV	mit, į	
9	ng phy	Medical	IF FEMALE:	·							
P.O. Box	In other Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?  1							very Day Year	
S,	es that igned t	by P	Part II. Other significant conditions co		-	lying cause given	in Part I.		obacco use contribute to		
ord	requir bould	eted	ACUTE CORONA							obably 4 Tunknown	
al Rec	: The law cate has I , page 2 s	Completed	STAPHYLOCOC	CUS AUREU	5 BAC	TERAET	NIA	24a. Was autop perfor	prior to or death?	topsy findings available completion of cause of 2 □ No	
<u> </u>	Physician: r this certifica aral director, p	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 1 1 Inpatient 2 □	EB/Outpationt 3	Othor	26. Place of Death			if.)	
י סל	g Phy ler this seral d	Ĕ	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury a Work?			dence 6 Other (Spec now injury occurred	my)	
Division of Vital Records,	or Attendin ter death. irector: Afi n by the fur	Certification: To	1 Lt Natural 5 Pending investigation 3 Suicide 4 Homicide (Month, Day, Year) Injury Work?  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Ru City or Town, State)						ral Route Number,		
<u> </u>	Hospital 24 hours a Funeral C etely filled i	Medical Ce		ysician: To the best of my kno liner: On the basis of examina and manner stated.							
:	Io the within To the comple	Me	29b. Signature and title of certifier			29c. License r	number		29d. Date signed (Month	n, Day, Year)	
			> Yask N	10		R	ES - 0	21	5/25/0	9	
		117									
	8		30. Name and address of person who of DR. ZAW MIN		n 23a) (Type, Prin AN OVER	t)	BALTIN	MADE	MD 213	125	

DHMH 17 Rev 1/2001

			1 - State Registrar	23State of Maryles	<b>19,009</b> 0 Ce	y 1098hBi 2 rtificate of	<b>be</b> lt <b>ho</b> an <i>Death</i>	d Mental Hy	rgiene Reg. No. 2009	18566
			1. Decedent's Name (First, Middle, Las	st)				2. Date of De	eath Day Year	3. Time of Death
	Physicia /Medic		400		Mi	ller		06	07 7009	15-22 PM
1	Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	r Location of D	eath	4c. County of Dea	ath
./			Shock Tray	MA Cent	er	Balti	more	0	N/A	
	Funeral Director		5. Social Security Number 6. S 201–16–4581	ex 7. Age (in yrs		If Under 1 Year Months Days	If Under 24 Hours N	Hrs. 8. Date of Bi Min. 12/09	71927 9. Bi	rthplace (State or Foreign lountry) PA
Т	pur w		Usual Residence of Decedent  10a. State 10b. County	10c C	ity, Town or Lo	cation				10d. Inside City Limits
	laryla sho	ō	,		*	OWINGS MI	110			1 □Yes 2 🛣 No
	28a-	Director	MD BALTI  10e. Street and Number	MUKE		10f. Zip Code	LLJ		10g. Citizen of What C	ountry?
	with a or		122A HARRY LANE			211	17		USA	•
	ns 23	Funeral	11. Marital Status	12. Was Decedent Ever in U	J.S. 13.			? (Specify Yes or No uerto Rican, etc.)		erican Indian,
21215-0036	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f show event, it is died Erschingt mitster rollfied a	by	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates:		lfYes, specify Cuba 1 □Yes 2 🛣 No	an, Mexican, P Specify:	uerto Rican, etc.)	Black, Whi	
ŏ	2 hou	Completed	15. Decedent's Ed	lucation	16a. Dece	dent's Usual Occup	pation		16b. Kind of Business	s/Industry
212	within 72 ho jiene. r than "natur In Wedien	ple	(Specify only highest gra	College (1-4or 5+)	(Give   life.	kind of work done DO NOT use retired	during most of d)	working	1	
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פ	nould be filed valued by the second marked other matic event, II	Be C	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle	e, Maiden Surname)	
<u> </u>	buld be the Mental arked o attic eve	70	JOHN	MI	LLER		SA	ARAH	SIL	VER
Maryland	is 1 and 2 should by Health and Men' item 27 is marked to other traumatic e	Ė	19a. Informant's Name/Relationship (	Type. Print)	19b. Maili	ng Address (Street	and Number o	or Rural Route Numb	ber, City or Town, State,	Zip Code)
_	1 and 2 Health em 27 l		ROSE MILLER / WI	FE	12	22A HARRY	LANE,	OWINGS M	ILLS, MD 2	1117
altımore,	of H		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐		Place of Dispo cemetery, crea	sition (Name of matory or other plac		Date	20c. Location - City o	
Ĕ	. Pages tment of tant: If it		4 □ Donation 5 □ Other (Specify		EBREW '	YOUNG MEN	S  06,	/09/2009	BALTIM	· ·
Balt	permit. Pac Departmen Important: any injury once.		21. Sign up of Funeral Servite Lice	NUGLY		2. Name and Addre			NSON & BROS PIKESVILLE	
			23a. Part 1. Enter the disease, or composhock, or heart failure. List only	plications that caused the dea	th. Do not en	ter the mode of dyir	ng, such as ca	rdiac or respiratory	arrest,	Approximate Interval Between
2	hysician	2 4	Immediate Cause (Final disease or condition	a. Sub Arachae				~	on	Onset and Death
	/Medical		resulting in death)	a. Due to (or as a conse	quence of): A	ccidenta	l Fa11	. )~		
	Examiner		Conspetibility for one differen	b. Hecicoscia	7 11.16	110		A PROVED BY MEDICAL	EVAINER	
	p #	ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):	,		PPROVED BY ME		
	ecute ind trans	Examine	that initiated events	C			CENTIFICATION.			
Š.	be executed ician and burial-transit	Ě	resulting in death) Last	Due to (or as a conse	quence of):					
9/8	ate hys	dical		d						
٥	leath certificate attending phys i for use as the l	Mec	IF FEMALE:	00 1/			-	-		
Š R	death c le attenc ed for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr	al death 3	Ectopic pregnanc	су		23d. Date of d Month	elivery Day Year
	the a	sic	1 □Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown	death 5L	Other (specify) _				
<b>7</b> .	hat tr ed by letac		Part II. Other significant conditions of	ontributing to death but not re-	sulting in the u	nderlying cause giv	en in Part I	23e. Did	tobacco use contribute	to the cause of death?
Hecords,	signe	<u>5</u>	The second secon	CAIDING FUNC	_	1×1212341	ad rouse	)   10	Yes 2∏XNo 3□	Probably 4 Unknown
Ö	requ hould	Completed	A SAMON CI	C CONT		- 101 001 11	-CACA			
မ္	hash e2s	훁	1 Jenuly	Soppor				— 24a. Was	opsy prior to	autopsy findings available o completion of cause of
<u> </u>	cate pag	S						1 □Yes	formed? death'	s 2 No
VITA	certiff ector	Be	25. Was case referred to medical examiner?	Hoopitals		Ott		Death (Check only	one)	
0	this aldir	2	1⊠Yes 2□No		ER/Outpatie		4 LI NUISI		sidence 6 Other (Sp	pecify)
ב	IIng I I. After uner	io	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	Wor	ryat k? lYes 2∭KNo		how injury occurred	1
DIVISION	ttenc death tor: the	Certification:	2 Accident investigation 3 □ Suicide 6 □ Could not be		UNK		ires Zpolivo	1 1111	(Street and Number or	Puml Poute Number
_ ັ	or A offer of Direction by	Ħ.	4 ☐ Homicide determined	building, etc. (Spec	ify)	- /		City or To	wn, Ştate)	1 RandallsTown
_	prtal burs a eral l		29a. Certifier 1 Certifying Ph	ysician: To the best of my kn	USPIT		ime date and		Old COUITR	(), MD
0:	To the Hospital or Attending Physician; The law requires that the of within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	edical		niner: On the basis of examir and manner stated.						
	ithin o the	Mec	29b. Signature and title of certifier	and mariner stated.		29c. Licens	se number		29d. Date signed (Mo	nth, Day, Year)
	- ≥ <b>=</b> ∀					0	0 / s	22020	syla-1	G
		1	20 Name of address of pares who	*	m 00=1 (T)	Drint)	OG Z P	22320	0610110	
			30. Name a maddress of person who	completed cause of death (Ite	m 23a) (Type,	Print)		_	OC #.5	
			Michael F. Ditil	llo.M.D.	7-		C .	] / L.		217-1
	Sta	te.	Michael F. Diti	L1o,M.D.  32. Registrar's Sign	22 S	Crien	STI	Baltimo	ec.mi)	21201

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2009 1:45A. JUNE 6, LEONARD J. MAKOWSKI, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** HARFORD UPPER CHESAPEAKE MEDICAL CTR. BEL AIR Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days Hours 1 XM 2 ☐ F OCT13.1934 MARYLAND 216-32-5626 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show 1 ☐Yes 2 XNo r than "natural", or items 23a or 28a-f sh the Medical Examiner must be notified Director HARFORD BEL AIR 10g, Citizen of What Country? 10e. Street and Number U.S.A. 21015 630 CAMELOT DRIVE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturat", or iten any injury or other traumatic event, the Medical Examiner once. 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 🏖 No Maryland 21215-0036 3 □ Wildowed 4 □ Divorced 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BETH STEEL IRON WORKER 10TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LEANA JANKOWIAK STANLEY MAKOWSKI 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 630 CAMELOT DRIVE BEL AIR, MD. 21015 LOUISE ANN MAKOWSKI Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SACRED HEART OF JESUS: 6-9-2009 BALTIMORE, MARYLAND 22. Name and Address of Facility KACZOROWSKI FUNERAL HOME, PA 21. Signature of Funeral Service Licensee 1201 DUNDALK AVENUE BALTIMORE, MD. 21222 Robert 23a. Part1. Enter the diseale, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 5 rears Coronary Artery Disease **Physician** disease or condition resulting in death) /Medical Hypercholedenolemia Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician; The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_ 2 Fetal death Month Day in the past 12 months? 1☐ Yes 2 🗷 No 4☐Pregnant at time of death 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Onknown Asbestosis, Emphysema Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an 1∏ Yes Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 27. Manner of Death 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier June 8, 2009 D39763 Le Finenden, M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2012 Tollgate Rd., Ste 102 Bel Air, MD 21015 Lee Tannenbaum, m.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Diseas. Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician 2009 June /Medical 4c. County of Deat 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Kaltimore Saltemore Under 1 Year | If Under aritas 9. Birthplace (State or Foreign If Under 24 Hi Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours South Carolina -22-9200 1 □ M 2 🛛 F Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Example with the medical Example. 1√XYes 2□No Directo Maryland Baltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21227 3308 onson Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes XXNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. hours after 1 ∐Yes 2√7 If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 □Yes XX No Baltimore, Maryland 21215-0036 Specify: Specify: W à 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) within 72 (Specify only highest grade completed) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland Claims Examiner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gladys Marie Pryor John Rufus Maynard ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Richard V Pryor P<sub>0</sub>A 2102 N VanBuren St Wilmington DE 19802 20c. Location - City or Town, State permit. Pages 1 a
Department of He
Important: If item
any injury or othe Method of Disposition

XX Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) June 12,2009 Baltimore, Maryland Woodlawn Cemetery 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Fad Mitchell-Wiedefeld Funeral Home Inc signature of Funeral Service Licensee MMIS 6500 York Road Baltimore, MAryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final eow s **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) malnutrition Examiner 1ems nronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner PAVJ burial-transi nemia that initiated events resulting in death) Last and Hospital or Attending Physician: The law requires that the death certificate be exect Due to (or as a consequence of) P.O. Box 68760 attending physician for use as the buria ears Physician/Medical signed by the attending I d be detached for use as IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 \( \subseteq \text{ Ectopic pregnancy} \) Month Year Day in the past 12 months? 5 ☐ Other (specify) 2 X No 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, Completed by 2)No 3 Probably 4 Unknown 1 🗌 Yes within 24 hours after death.

To the Funeral Director; After this certificate has been s completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 □No 1 ☐ Yes 2 No 1 □Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) USSISTES | IV 2**X**1No 2 ER/Outpatient 3 DOA 1 🗌 Inpatient 1∐ Yes Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my online, death occurred. 29a. Certifler Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar venue

Baltimor

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

en son

32. Registrar's Signature

(Mn)

JUN 1 () 2009

Month, Day, Year)

110

31. Date filed (

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month 1035 URW012 2009 June 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltinute C If Under 1 Year | If Under 24 Hrs. 91 Juspital 58 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) Social Security Number 6. Sex Months Days 1 □ M 2 □ F Jul 12, 1926 Maryland 218-22-6652 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 No N/A Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21216 U.S.A 2930 Mosher Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2☐No Specify: If Yes, Give Year or Dates Specify Black 3 - Widowed 4 - Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mariah Holland Clifton Howard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2930 Mosher Street Baltimore, Maryland 21216 Vernon Norwood 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐xBurial 2 ☐ Cremation 3 ☐ Removal from State 06/15/09 Crownsville, Md 5 ☐ Other (Specify) 4 Donation Crownsville Veterans Cemetery 22. Name and Address of Facility celLicense 21. Signature of Funeral Ser Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 2121 to not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Mocard BY disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) 3d. Date of delivery Day Year Month se contribute to the cause of death? No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No

**Physician** /Medical Examiner The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

**Examiner** 

10a. State

**Funeral** 

Director

28a-f show

Director

Funeral

þ

Completed

Be

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r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at

death with the Maryland

within 72 hours after

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event, Item Many Injury or other traumatic event.

Baltimore, Maryland 21215-0036

Examine attending physician and for use as the burial-transit Physician/Medical sate has been signed by the page 2 should be detached Be Completed by certificate funeral director, Certification: To this After t death. within 24 hours after death

To the Funeral Director:
completely filled in by the

Cause (Disease or injury that initiated events resulting in death) Last	c	uence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c	aldeath 3□Ecto					23d. Date of deliver Month D
Part II. Other significant conditions	contributing to death but <b>n</b> ot res	ulting in the underly	ing caus	se given in Part I.		23e. Did tobacco	o use contribute to the 2 ☐ No 3 ☐ Proba
						24a. Was an autopsy performed?	
25. Was case referred to medical				26. Place of De	ath (	Check only one)	
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2	ER/Outpatient 3[	] DOA	Other: 4 Nursing	Home	e 5 ☐ Residence	6 ☐ Other (Specify
27. Manner eath 1 atural 5 □ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	- 1	. Injury at Work?	28	d. Describe how in	jury occurred

3 Suicide 4 Homicide

(Check only

29a. Certifier

Medical

State Registrar

investigation

6 Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

JAMEE +

29b. Signature and title of certifier

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RUB 2000 Baldinune

31. Date filed (Month, Day,

32. Registrar's Signature

and manner stated.

Libber

or Attending Physician:

To the Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #5, perFh G892 6/16/09 TT Health and Mental Hygiene Certificate of Death Reg. No: 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** NEUBERT June 6, 2009 10:45A MARY FLANIGAN KATHLYNE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson 109 Kenilworth Park Drive #30 If Under 1 Year if Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days 1 M 2 X F  $217 - 14 - \frac{3207}{3205}$ 88 February 27,1921 Maryland Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 1 □Yes 2XXNo Director Baltimore Maryland Towson 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21204 109 Kenilworth Park Dr., Apt. 3C United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: white þ 3XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alice Karsner John Flanigan 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21204 Towson, MD Patricia Schuebel/daughter 811 Boyce Ave. 20c. Location - City or Town, State 20b. Piace of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Bunal 2 XCremation 3 ☐ Removal from State Baltimore, Maryland Green Mount Crematory June 8,2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc
6500 York Rd. Baltimore, MD 21212 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CEREBROVASCULAR ACCIDENT Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or an a consequence of) Examiner ed by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4□Pregnant at time of death 9□Unknown 9 Unknow After this certificate has been signed by inneral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CARDIOMYOPAT 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Be Completed FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an 1∏ Yes or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 5 Residence 6 □Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 1 🗌 Yes 1 Inpatient Certification: To 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 28c. Injury at Work? (Month, Day Year) Injury 1 Naturai 2 Accident 5 Pending investigation s after death. М 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in my opinion death occurred. within 24 hours a 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8, MD 124 2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10b perFH, G893, 7/27/09, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Gerard Novall Edward 2009 /Medical 4a. Facility Name (If not institution, give street and number)
University of Maryland Medical System 4c. County of Death 4b. City, Town, or Location of Death **Examiner** None 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** XXM 2 F Months Days **Director** 218-64-6582 JAN 19,1955 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a. \*\*\* ADDR. 10d. Inside City Limits 10a, State 10b. Count 10c. City, Town or Location Harford 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Baldwin 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3202 New Fane Court 21013 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXVo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married Married 1 □Yes XXNo White Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Vice President Banking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edward Francis Novak Jacqueline Bianca 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Travers Novak Wife 3202 New Fane Court Baldwin Maryland 21013 20a. Method of Disposition
1 ☐ Burial 2XX remation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State GreenMount Crematory June 9,2009 4 Donation 5 □ Other (Specify) Baltimore, Maryland 22. Name and Address of Farint Chell-Wiedefeld Funeral Home Inc at nature of Funeral Serv e Lićense 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) aftending physician a for use as the burial-Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been si e 2 should l Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate ha autopsy performed? 1 □ Yes 2 □ No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of After t 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number wo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Farrey S Greene ST Baltimore, MD 31. Date filed (Montil, Day, Year) 32. Registrar's Signature State **JUN 1** 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 857 Certificate of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 8:55 AM **Physician** 09 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Baltimore County **Pickersgill** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) January 31 1909 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 □ XF 216 38 6909 100 Baltimore Co., Md. Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State "natural", or Items 23a or 28a-f show idical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Baltimore Baltimore County 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21286 USA 1000 East Joppa Road Apt. 500 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Completed by 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 27 Is marked other than "nature traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping-Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be f and Mental ! Josephine Myers Gilbert Smith ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 602 Laurel Avenue Laurel, Maryland 20707 W. Walter Ortel Health tem 27 I Item ( 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Michael's Luth. Ch. Cem. June 10 2009 Baltimore, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home Inc 7401 Belair Pood Baltimore, Maryland 21236 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. e, or complications that caused the death. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Year Month Day 4⊡Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably 4 Unknown 1 🗌 Yes page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate has 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending P s after death.

al Director: After sed in by the funer. Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by To the Hospital c within 24 hours aff To the Funeral D 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

State Registrar

31. Date filed (Month, Day, Year

29b. Signature and title of certifier



30. Name and address of person who completed cause of chath (Item 23a) (Type, Print)

6 761 N. Charles St. Balto. and

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** June 5, William Delmas Peacock 2009 11:30p<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Genesis Eldercare Brooklyn If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Jan. 23 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F 216-68-3728 1948 Maryland Director 61 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show traumatic event, the Medical Exercions a ust be notified at MD N/A Baltimore 1 No 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code within 72 hours after death with USA 21230 1604 Webster Street items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ▼ No Specify: If Yes, Give Year or Dates: White þ 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Agnes Hesse William H. Peacock 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marian Miller 1604 Webster Street Baltimore, MD 21230 sister permit. Pages 1 and Department of Healt Important: If item 2: any Injury or other i 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State June 9, 2009 Glen Burnie, MD Glen Haven Memorial Park 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility McCully Polyniak Funeral Home PA 21. Signature of Fineral Septice bice see ONAC 130 E. Fort Avenue Baltimore, MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** hour /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). To the Hospital or Attending Physician; The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical phys the l as attending IF FEMALE: for use yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐No ed by the a Division of Vital Records, P.O. 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown icate has been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 ☐ Yes 2 No 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 2 No Other: 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 24 hours after death

To the Funeral Director:
completely filled in by the

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

w

Dennis

29b. Signature and title of certifie

lan N.



901

**ORIGINAL** 

29c. License number

29d. Date signed (Month, Day, Year)

21230

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) <u>3:0</u>0<sup>a</sup>м Day **Physician** May 28, Jackson I. Pumphrey, Jr. 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Chestertown Nursing Home Chestertown Kent Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day. **Funeral** Days 2/22/1932 161-24-4634 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, It with alical Examiner must be motified. 1 Yes 2 □ No CA Riverside Sun City Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 92586 28620 Worcester Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Black, White, etc. 72 hours after 1 | Yes 2 | No
If Yes, Give Korean
Year or Dates: Korean 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify 2 3 ☐ Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Aerospace Salesman 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Irene Mae Redifer Jackson I. Pumphrey, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 28620 E. Worcester Rd. Sun City, CA 92586 Department of Health a Important: If item 27 is any injury or other tra once. Edward D. Clark, friend 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory June 4,2009 Beltsville, MD 22. Name and Address of Facility Rapp Funeral & Cremation Svcs. 21. Signature of Funeral Service Licens 933 Gist Ave. Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Backerial disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ganz Sequentially list conditions Due to or as a conse undee of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed phero attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No P.O. the 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Atter this certificate has been signed funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an autopsy performed? 1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 □Yes 2 □ No 2 Accident completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and tit MS 0 30. Name and address

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Physician Rasma A. Plucis 12:40P 2009 June 5, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Rockville Collingswood Nursing Home Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year Days Hours Min. 1 ☐ M 2 🕅 F 578-46-2036 Feb. 10, 1924 Latvia Director 85 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County ral", or Items 23a or 28a-f show Examiner must be notifled at 1 TYes 2 □ No Directo Maryland Montgomery Rockville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 402 Hurley Avenue #202 20850 Latvia permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23; any Injury or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: ģ White 3 XWidowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerk Grocery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alma Blums ပ Adolfs Krasts 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Astrida Plucis-Turkopuls/Daughter 8 Fisk Circle, Annapolis, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition June 7, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematorium 2009 Alexandria, Virginia 22. Name and Address of FacilityRobert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature aral Service Licers M00803 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the burial Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 📉 No the 9 Unknown g | Unknown signed by 1 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an has autopsy 2 No 1∐ Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2/ No 1 Inpatient P 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Natural 2 Accident (Month, Day Year) Injury 5 | Pending within 24 hours after use....

To the Funeral Director: Aft investigation М 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 1 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type Print)

SAYED EISA 44AD TOTO Molecular By Rock Ulle, MD 2085 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) May 27, 2009 5:30 pm **Physician** Postell Bobby Steven /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner Clinton 5800 San Juan Dr. | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Min. ) | 7-09-1 955 9. Birthplace (State or Foreign Country) 6. Sex 12 M 2 ☐ F 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** 53 579-76-9477 Director Usual Residence of Decedent 10d. Inside City Limits 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, If a Medical Examiner must be rediffed at once. 1. Yes 2 □ No Clinton MD PG Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 5800 San Juan Dr. 20735 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status Specify: Black 1 Never Married 2 Married 1 □ Yes 2 □Xio Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry Decedent's Usual Occupation
 (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Postell Beatrice Ludell Murray ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5800 San Juan Dr. Clinton, MD 20735 19a Informant's Name/Relationship (Type. Print) Eliska Postell/ Wife Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)

Riverdale Pk Crem. Date 20c. Location - City or Town, Sta 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Ronald Taylor II FH 21 Signatur of Funeral Service Licensee 10583 Middleport Ln. White Plains, MD Hondal 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 72 hrs **Physician** Septicaemia /Medical Due to (or as a consequence of): Examiner 1/2 wks Abdominal Surgery Repair Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed 5-7 yrs sician and burial-trans Non-Insulin Dependent Diabetes Due to (or as a consequence of): Box 68760, attending physician for use as the burial Urethral Cancer Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No Ö cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Possible Septic Shock 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy 1 Yes 2 □ No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, F. 25. Was case referred to medical examiner?
1 Yes 2 □ No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Division of 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier her: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 2 Medical Exami 29d. Date signed (Morgth, Day, Year) 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6201 Greenbelt Rd. College Park, MD 20708 Dr. Nicholas Azinge 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

09-04525 Dana Richardson

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 18577

		For State		Certific	cate of	Death				. No.		
Physicia		Decedent's Name (First, Middle,Last	)						Date of Death Month	Day Yea	3. Time of 1130	
edical Examir	er	Dana Richard	Ison					J	une 7, 200	)9`		1115
		a. Facility Name (if not institution, give	street and number)		41	o. City, Town,	or Location o	of Death		4c. County of	of Death	
		925 Brooks Lane Apt. 1				Baltimore						
Funeral		5. Social Security Number 6. Se	x 7. Age	(In yrs. last b	irthday)	If Under 1 Ye				(MM/DD/YYYY	9. Birthplace (St. Foreign Mary.	land
Director	-	214 04 0720 1X	M 2 F	44	Yrs.	Months Da	ays Hours	Min.	09/27/	1964	Country)	7 - 2.7
		214-84-0730 1 Δ  Usual Residence of Decedent	1W1 Z1			1						
any		10a. State 10b. County	1	Oc. City, Tov	vn or Locatio	on						le City Limits
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h the 3a or		925 Brooks Lane A			140.44	Decedent of	21217	nin2 / Specif	fy Ves or No.		- American Indian	. Black.
h wit	uneral	11. Marital Status  1 X Never Married 2 Married	12. Was Decedent 9 Armed Forces?	ever in U.S.	If Ye	es, specify Cub	an, Mexican	, Puerto Ric	an, etc.)		e, etc.	
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n 72 nan "	Completed	Elementary/Secondary (0-12)	College (1-4 of 5	<sup>-</sup> '	T	orter				Nurs	ing Home	
withi withi iene.	Ē.	17. Father's Name (First, Middle, Last				-	T 18 Mothe	r's Name (Fi	irst. Middle, N	Maiden Surname		
21215-0036 July be filed within 7 Mental Hygiene, marked other than it event, the Medical									e Foot			
121 d be lental	o Be	Douglas Richards  19a. Informant's Name/Relationship (*)			19h. Mailing	Address (St					wn, State, Zip Code	e)
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	ř	Douglas Richardso									cyland 21	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 ment of Health and Mental Hygiene. Iant: If item 27 is marked other than ' or other traumatic event, the Medical	ŀ	20a. Method of Disposition	ZI , I della	20b. Plac		ition (Name of			Date	20c. Location	- City or Town, Sta	ate
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Page nent ant: or of		4 Donation 5 Other Specify	n	Tri		emeter					ore, Mary	
Baltimore, MC permit. Pages I and 2 s Department of Health an Important: If item 27 injury or other transmanning or	1	Signature of Funeral Service Lice	nse		22. N	lame and Addi	ess of Facili	The	Derric	k C. Jo	ones F/H	P.A.
മെട്ട്ട്		Charles .	C. 1		461	1 Park	Hgts.	Ave.	, Balt	net shock or h	Maryland Approx	kimate Interval
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587 artific ling p		23b. Was decedent pregnant in the past 12 months?	1 Live birth	time of doot		etal death	3 Ector	oic pregnant	су	Month	Day	1 Gai
Box 687: death certific	sician	1 Yes 2 No 9 Unknow		time of death	5 _ 0	ther (Specify)						
hed f	Phy	Part II. Other significant conditions		h but not resi	ulting in the	underlying cau	ise given in l	Part I.	23e. Did	obacco use cor	ntribute to the caus	e of death?
ires that the de signed by the		Part II. Other significant conditions	Contributing to deal	11 54: 115: 155:	<u></u>		ŭ		1 Ye	s 2 V No	3 Probably 4	Unknown
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ecc he lav nte ha	Completed by									2 No	1 🗸 Yes	2 No
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/ita sicia iis cel firect	Be B	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpati	ent 2 E	R/Outpatier	nt 3 DOA	Other <sub>4</sub>	Nursing	Home 5	Residence 6	Other: Scene	
Division of Vital Records, tal or Attending Physician: The law require and agardean. After this certificate has been sifted in by the funeral director, page 2 should b	ا ي	27. Manner of Death	28a. Date of Inj	ury 2	28b. Time of	Injury 28c	Injury at Wo	ork? 2	28d. Describe	how injury occ abbed and c	urred	
on of the further of	[ 등	1 Natural 5 Pending		Teal)	FOUND: 1115 hrs	1	Yes 2	✓ No	oubject ste	ibbed and e		
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Div al or al Diu	Certification:	3 Suicide 6 Could no determin		ulti-Family	Apt.			9	or Town, 25 Brooks	Lane Apt. 1, E	Baltimore, MD	
Division of Vital Records, P.O. Box 68: To the Hospital or Attending Physician: The law requires that the death certificate the Funeral Birector: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as it		4 Homicide  29a. Certifier 1 Certifying Phys	inion. To the hest of r	ny knowledge	death occi	urred at the tin	ne, date and	place, and o	due to the car	use(s) and man	ner as stated.	
the H nin 24 the F	Medical	(Check only one) 2 Medical Examir	er:On the basis of ex	amination and	d/or investig	ation, in my op	inion, death	occurred at	the time, dat	e and place, an	d due to the cause	e(s)
To To To To To	Med	29b. Signature and title of certifier	and manner stated				cense numb				igned (Month, Day	
		his his	WO				C.M.E.			June 8, 2	2009	
		OO Name and address of account	n completed course of	death (Item 1	23a)							
	1	30. Name and address of person wh	o completed cause of Medical Examina		Penn Stre	et, Baltimo	ore, MD 2	1201				
				ar's Signatur								
Regi	itate stra:	11111 1 0 000		1.	bar	Kal						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 1:45 A.M June 9, 2009 Ruth Alma Rost 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Carroll Westminster Carroll Lutheran Village If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Min. Months Days Hours 1 □ M XXF 1924 North Carolina 84 July 12, 220-18-2762 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ∐ Yes 2 No Baltimore Hampstead Maryland 10g, Citizen of What Country? United States 10e. Street and Number 10f. Zip Code 21074 19219 Falls Road America 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2XXNo 11. Marital Status 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 □Yes ŽXNo Specify. Specify: White XXWidowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Clothing Seamstress 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rosie Arnold Millard Smith Comer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 19225 Falls Road, Hampstead, Maryland 21074 Richard E. Rost (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) June 13, 20c. Location - City or Town, State 20a. Method of Disposition PABurial 2 ☐ Cremation 3 Removal from State Hampstead, Maryland 2009 5 Other (Specify) Church Cemetery 4 ☐ Donation 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of Funeral Service Licensee Charmil Dr. Manchester, MD 21102 3296 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Reculturas disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as consequence of): gamor Due to (or as a consequence of): If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
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1 ☐ Yes 2 ♣ No 24a. Was an autopsy performed? 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work?

**Physician** /Medical Examiner the death certificate be executed

physician

certificate

After this

...c nospital or Attend within 24 hours after death. To the Funeral Director: At completely filled in hours.

funeral director.

Physician

/Medical

Examiner

**Funeral** 

Director

iral", or items 23a or 28a-f show Examiner must be notified at

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2 should be fil n and Mental Η

Pages 1 and 2 s ment of Health ar

7 is marked other than "natu traumatic event, the Medical

Department of Health Important; if item 27 any injury or other tronce.

27

Director

Funeral

Completed by

Be

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death with the Maryland

72 hours after

Baltimore, Maryland 21215-0036

68760,

P.0.

Records,

Division of Vital

Physician:

Examine sician and burial-tran the attending p detached cate has been signed by page 2 should be detach

Physician/Medical þ Completed

Be

Certification: To

IF FEMALE 23b. Was decedent pregnant

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yes 2 X No 27. Manner of Death 5 ☐ Pending investigation 1 Natural М 1 ☐ Yes 2 ☐ No

2 Accident 3 Suicide 6 Could not be 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29a. Certifier (Check only

> 29c. License number 51705

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Malcolm DR, west minst

answara (M)

ANSURIU 31. Date filed (Month. Day, Year,

JUN 1 0 2009

and manner stated.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** (In yrs, last birthday) **Funeral** Security Number 7. Age Days Hours Months Usual Residence of Decedent 1 □ M 2 **X** F Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at 1 Yes 2 □ No Director more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò or items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: ğ 3 Widowed 4 Divorced 'natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life., DO NOT use retired) Department of Health and Mential Hygiene Important: If item 27 Is marked other than any Injury or other traumatic event, It a Maonce. Elementary/Secondary (0-12) College (1-4or 5+) DIME ne 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ 19a. Informant's Na e/Relationship (Type. Print dairy Ter) 19b. Mailing Address (Street, and Number or Rural Route Number, City or Town, State, Zip Code) Kins-Thornton 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Ave. 23a. Pau Enter the dis shock, or heart fallu Immed Cause (Final Enter the d sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lure. List only one caus, on each line. Approximate Interval Between Onset and Death Physician ALBOUDSCUPAL disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes Certification: To 2 ₩No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Mann Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director A completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

B√ State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

JUN 1 0 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

**ORIGINAL** 

(LEISTENITOWA

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc, 12 per th 8892 6-10-09 vt.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Kimie Robinson Month Day Year OS 2009 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimare If Under 24 Hrs. ourtland Gardens Nursing & Rehab Baltimore Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) Hours Months Days 1 M 2 ▼ F 85 Japan Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No Glen Burnie Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number U.S.A. 21061 6650 Whitmore Court #C152 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 █€No Specify: Japanese 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Home Maker 12 -18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Yoshi Fumv Kato Kazu 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6650 Whitmore Ct. # C152 Glen Burnie, MD 21061 Kimie Sakamoto Robinson/Self 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Jun 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Beltsville, Maryland Chesapeake Crematory Inc. 2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee M01443 Cremation and Funeral Alternatives Maryland 21286 8717 Green Pastures Drive Baltimore, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1. 4 Cold of in hech ca Immediate Cause (Final 150000

/Medical **Examiner** Division or Vital Records, P.O. Box 68760, Robinson, Kimmie 195Am

Physician/Medical Examiner burial-trar been signed by the attendin should be detached for use Completed by within 24 hours after death.

To the Funeral Director: After this certificate has To the Hospital or Attending

**Physician** 

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

Be

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural" ~ :-- any injury or other traumatic event.

disease or condition resulting in death)	a. Due to (or as a consequence of):	ajour rej	Cric		CISINON
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):  c. Due to (or as a consequence of):	in disect	_		76minle
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No		opic pregnancy her (specify)		23d. Date of de Month	ivery Day Year
9 ☐ Unknown  Part II. Other significant conditions	contributing to death but not resulting in the under	lying cause given in Part I.		2 No 3 P	o the cause of death?  robably 4 Unknown  utopsy findings available completion of cause of
25. Was case referred to medical		26. Place of De	ath (Check only one)		
examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	Other	lome 5 ☐ Residence	6 Dother (Spe	ecity) HUSPICE
27. Ma  r of Death	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how it	njury occurred	
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		factory, office	28f. Location (Street City or Town, S	t and Number or Fi tate)	ural Route Number,
29a. Certifier 1 Certifying I (Check only 2 Medical Ex	Physiclan: To the best of my knowledge, death or aminer: On the basis of examination and/or inves and manner stated.	ccurred at the time, date and plac tigation, in my opinion, death occ	e, and due to the caus curred at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
29b. Signature and title of certifier		29c. License number	29d.	Date signed (Mon	th, Day, Year)
DOILO		1944817	[]	ineo	8 2009

State

31. Date filed (Month, Day, Year)
JUN 1 0 2009

LRD, Pikesville, MD. 21209

son who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . <sup>Day</sup> 2009 Month 7:42 PM M **Physician** 3, Luis Jacinto Rojas /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/16/1949 9. Birthplace (State or Foreign Country) Peru 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M M 2 □ F 59 **Director** 595-32-5783 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show traumatic event, the Medical Examiner roust be notified at 1 ☐ Yes 2 X No Director Rockville MD Montgomery 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō USA 20853-23a 14205 Chesterfield Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married 1 □Yes 2 N If Yes, Give Year or Dates: 2 No Maryland 21215-0036 1 XYes 2 □ No Specify: Hispanic ð 3 Widowed 4 Divorced 'natural' Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Health Care filed within 7 I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Worker marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental I Be pe Celia Rosales Lucio Rojas ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 14205 Chesterfield Road Rockville, MD 20853-Aracelli D. Rojas/Wife Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Jun 6 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Beltsville, Maryland 2009 Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) M00382 22. Name and Address of Facility
Rapp Funeral & Cremation Services Silver Spring, Maryland 20910-933 Gist Ave. dheren 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** HEMORRHAGE disease or condition resulting in death) /Medical Due to (or as e consequence of): Examiner THROMBOCYTOPENIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner 8 WEEKS requires that the death certificate be executed MYELOGIENOUS ACUTE attending physician and for use as the burial-trar Due to (or as a consequence of): 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 □ Yes 2 □ No Dey 4 Pregnant at time of death 5 Other (specify) hed by the detached o 9 Unknown 9 Unknown iis certificate has been signed by director, page 2 should be detach σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ੬ 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 **V** No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To ð 27. Many er of Death 1 ▼ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0066990 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROCKVILLE M'D 6420 ROCKLEDGE 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

Amend 20a-b, per fin 8893 //16/09 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 11:55 GM **Physician** Spencel Tune 2009 ames /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Itemore Secons es dal If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Age (In yrs. last birthday) 8. 5. Social Security Number 6. Sex Year) **Funeral** Hours Months Days Min. 92 1 ☑ M 2 ☐ F Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Eran instruments to notified at 1 Yes 2 □ No Director nore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1 and 2 should be filed within 72 hours after death with Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No Specify 2 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, It In Moonee. Elementary/Şecondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) Sister 19a. Informant's Name/Relationship (Type. Print) # altimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 7/14/09 20a. Method of Disposition Pages 1 Mcemetery crematory or other place) 1 X Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation / 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses J0: Russ W. uner 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 30 minutes **Physician** patro /Medical Due to ( as a consequence of): Examiner para cell Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No the detached 9 Unknown 9 Dunknown After this certificate has been signed by funeral director, page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 🗌 Yes 2₽No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 □Yes 2 □No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28h Time of 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: A 2 Accident the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier completely within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 105 31. Date filed (Month, Day 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month SHARE HELEN 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) BALTIMORE PIKESVILLE EMERITUS OF PIKESVILLE Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Par) 1921 5. Social Security Number 7. Age (In yrs. last birthday) Months Min 1 □ M 2 🛛 F PA 87 181-14-0151 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 X No COOK CHICAGO IL 10g. Citizen of What Country? 10e. Street and Number 3450 LAKE SHORE DRIVE, #1403 USA 60657 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 X Never Married 2 ☐ Married 1 □ Yes 2 No WHITE Specify. 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DEPARTMENT STORE BUYER RETAIL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) KLEVAN FRIEDA SHARE S<sub>0</sub>L 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4 CANDLEMAKER CT., #206, BALTIMORE, MD JACK SHARE / BROTHER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State BETH EL MEMORIAL PARK 06/08/2009 RANDALLSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Pineral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a consequence of) Due to (or as Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 🗆 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 T Yes 24a. Was an

**Physician** /Medical Examiner

Department of Health a Important: If item 27 is any Injury or other tracence.

**Physician** 

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

Be

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7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, 13s Modical Examination at the notified at

Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.

and Mental Hygiene.

Baltimore, Maryland 21215-0036

/Medical

Examiner burial-tran Completed by Physician/Medical

and attending physician ate has been signed by the atte page 2 should be detached for To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I Be Certification: To

law requires that the death certificate be executed

Attending Physician:

Division of Vital Records, P.O. Box 68760,

IF FEMALE:
23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☐ No
9 🗆 Unknown
Part II. Other significant cond

25. Was case referred to medical examiner?

2

1 ☐ Yes

27. Manner of Dea

2 Accident

4 Homicide

3 ☐ Suicide

autopsy

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐ No

			26. A	ace of Death (C	heck only one)	
ospital:	2 ER/Outpatient	3 ☐ DOA	Other: 4	Nursing Home	5 Residence	6 ☐ Other (Specify,
28a Date of Injury	28h Time of	290	Injury of	284	Describe how inju	ury occurred

(Month, Day, Year) Injury 5 Pending investigation 6 Could not be 28e. Place of Injury - At hom building, etc. (Specify) At home, farm, street, factory, office

Work? 1 ☐ Yes 2 ☐ No

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

injury occurred

29d. Date signed (Month, Day, Year)

29a. Certifier

determined

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Н

21208 Ste#300 Balto. MD

State Registrar

Medical

31. Date filed (Month, Day, Year) JUN 1 0 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year MORENO SUTLIFF Month **Physician** 06,2009 20 June GLORIA /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Spring Montgomen Sandy Brooks Grove Rehabilitation and Nursing Center If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Year **Funeral** Months Min. 1 □ M 2 🖔 F Days Hours November 19, 1928 Ecuador 80 219-54-5764 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be netitied at 1 ☐Yes 2X No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 72 hours after death with 20906 United States 15115 Interlachen Drive #803 Funeral 14. Race - American Indian. Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2K Married 1XiYes 2□No Specify: Ecuadorian Baltimore, Maryland 21215-0036 Specify: δ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than ' College (1-4or 5+) Self-Employed Artist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If item 27 is marked oth any injury or other traumatic event Be Enrique Moreno Clara Jarrin ဥ 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14600 Farming Way, Centreville, Virginia 20120 Joseph Gregory Sutliff/Son 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition June 11, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 Silver Spring, Maryland Gate of Heaven Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 21. Signatu of Funeral Service License Banyon 7557 Wisconsin Avenue, Bethesda, Maryland 20814 a, M01546 23a. Part v. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) wall myocardial weeks interolateral **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed burial-transit and Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the law requires that the death certificate as IF FEMALE for use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) 1 ☐Yes 2 No P.0. 9 Unknown detached 9 Unknown ss been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown dementio Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate has page 2 2 No 1 ☐Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4™ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 27, Manner of Death 5 Pending investigation 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No filled in by the 3 Suicide 6 □Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Example 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D42046 STAFF PHYSICIAN TWO. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 18100 Slade School Road Sandy Spring, Maryland 20860 0 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006 OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend State of Maryland / 8892 remember of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 15:10 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Baltimore
Vear If Under 24 Hrs. Baltimore 8. Date of Birth (Month, Day, Year) 11-26-1926 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year 4 Hrs. Months Days Min Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 ☐ No imore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12. Was Decedent Ever in U.S. Armed Forces? 1 Dres 2 □ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify: Blac 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0,12) College (1-4or 5+) <u>Dervisor</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. lones/Daughty Story

edb. Place of Disposition (Name of cemetery, crematory or other place) Frank Windsor Mill, MM Z1244

20c. Location - City or Town, State Kazerrian 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State vaugho c. Greene funda is 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Randalistown, MD 2133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as caldiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final 100 disease or condition resulting in death) Due to (or as a conseque f): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (prisease of injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 □ No

Physician /Medical Examiner

**Physician** 

/Medical

**Examiner** 

10a State

**Funeral** 

Director

ral", or items 23a or 28a-f show Examiner must be notified at

**Funeral Director** 

Be Completed by

2

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene.

7 is marked other than "natu traumatic event, the Medical

Department of Health ar Important: If item 27 is any injury or other trauonce.

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar After this

Division of Vital Records, P.O. Box 68760,

Physician/Medical Completed Be Medical Certification: To

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

State Registrar

29b. Signature and title of certifier

25. Was case referred to medical examiner?

5 Pending investigation

6 Could not be

1∐Yes 2∏No

27. Manner of Death 1 Natural

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

and manner stated.

Date of Injury (Month, Day, Year)

29c. License number

Hospital

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 6,2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ☐ Yes

24a. Was an autopsy rmed? 2 ☑ No

1 ☐ Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d, Describe how injury occurred

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

2 No

of death (Item 23a) (Type, Print)

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

10 V

09-04419 Bren

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene

2009 18587

nda Thorton		State of Maryland / Department of Health and Meritain hystor state  Certificate of Death			
	Red	vietrar	Reg. No 2. Date of Death		3. Time of Death
Physician		Decedent's Name (First, Middle,Last)	June 3, 2009	Year	1025 hrs
Examin		Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	4	c. County of Death	
	40	4001 Bonner Road Baltimore		N/-	halass (State or Foreign
Funeral	5.	Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	8. Date of Birth (MN	//DD/YYYY) 9. BIT	hplace (State or Foreign untry)
Director	1	10 50 927/ 1 M 2XF 57 Yrs. Months Days Hours Min.	July 1,1	1951 M	aryland
		Sual Residence of Decedent			10d. Inside City Limits
any	_	la. State 10b. County 10c. City, Town or Location			1 Yes 2 No
<b>*</b>	۱	Md. NA Baltimore	100.0	itizen of What Cou	ntry?
laryla 28a-f	Director 7	De. Street and Number	109. 0	1101	a'
15-0036  filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f show t, the Medical Examiner must be notified at once.	<u>ة</u> ا	LONI RONNER Rd A LEIZIN	anify Vac or No-	14 Race - Amer	ican Indian, Black,
with ns 23 be no	Funeral	12. Was Decedent Ever in U.S. Armed Forces?  Armed Forces?	Rican, etc.)	White, etc.	
death	֓֟֟֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	Never Married 2 X Married 1 Yes 2 X No		Specify: R	ack
after all", c	<u>ا ح</u>	or Dates:		. Kind of Business.	Industry
hours matur Zxam		during most of working life. DO NOT use reti	red)	0 0 0	
36 n 72 nan " lical J	ompleted	1) / lerk		SSA	
5-0036 iled within 7 Hygiene. I other than the Medics	E	7. Father's Name (First, Middle, Last)	e (First, Middle, Maid	en Surname)	
al Hys	Be C	Lacou Banaett	ra Ko	indall	- Zin Codo)
D 21215-0036 should be filed within 72 hours after and Mental Hygiene. 7 is marked other than "natural", natic event, the Medical Examines.	ᆰ	9a. Informant's Na/he/Relationship (Type, Print) (Husband) 19b. Mailing Address (Street and Number or	Rural Route Number	City or Town, Sta	1/2 2/21/
e, MD 21215-003 1 and 2 should be filed within Health and Mental Hygiene. Tiem 27 is marked other the	ļ	Mr. Keginal A hornton 400 Bonner A  20b. Place of Disposition (Name of cemetery,	Date 20	oc. Location - City of	or Town, State
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examine:		crematory or other place)	1	1)	Mill MI
MOF Pages lent of lant: If	- 4	Towards & Tother Specific	10/2009 (	JWINGS	MITIS, Ma.
Baltimore, permit Pages 1 a Department of He Important: If ite	17	22. Name and Address of Facility  1. Signature of Funeral Service Licensee  1. Signature of Funeral Service Licensee  1. Signature of Funeral Service Licensee	Funeral,	Home, P.	A1716
<b>D</b> 89 E	1.	Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac	or respiratory arrest,	shock, or heart	Approximate Interval Between Onset and
Physician	1	I failure List only one cause on each line.			Death
ledical _xaminer		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):			
		h			
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	Examiner	cause. Enter Underlying Cause (Disease or rinjury that initiated Due to scripting in death). Last  Due to (or as a consequence of):			
cecuted n and - transit		events resulting in death) case		902 7/1/	709 TT
0, be executed sician and ourial - trans	edical	X UNPENDED #1 as noted, 23a,PII,27,28a-f	,permr, g	073 //14/	11
<b>60,</b> nte be ex hysician e burial	Med	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deli-	very Day Year
587 ertifica ling p	sician/M	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic preg	inancy		1
Box 6876( death certificate the attending phy ed for use as the b	sici	1 Yes 2 No 9 V Unknown 9 Unknown			
that the derned by the second of	Ph.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			e to the cause of death?  Probably 4  Unknown
F.O. ires that the signed by I be detach	व	Liver cirrhosis			e autopsy findings available
ords, w require s been si should b	ed		24a. Was ar autops	y prior	to completion of cause of
COF law r has b	Completed by		perform 1 <b>V</b> Yes 2		Yes 2 No
of Vital Records, ng Physician: The law requir Met this certificate has been s meral director, page 2 should 1		25. Was case referred to medical 26.Place of Death (Che			
Vital I ysician: his certifi director,	Be	examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA		Residence 6 🗸 C	ther: Scene
n of V ling Phy: After thi funeral d	<u>ا۔</u>	27 Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe h	ow injury occurred	
OD C tending eath or: All	tion	1 Natural 5 Pending Fd 6/3/2009 Fd 1000 hrs 1 Yes 2 No		teres and Number (	or Rural Route Number, City
Division  al or Attendir  rs after death.  al Director: A	fica	2 Accident Investigation 3 Suicide 6 X Could not be Residence 1 Suicide 1 Su	or Town, St	ate) 4001 B	or Rural Route Number, City
ital o	Certification:	determined (Specify)			stated.
Division of Vital Records, P.O. Box 68766 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the L		29a. Certifier (Check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred manner stated	and que to the cause ed at the time, date a	and place, and due	to the cause(s)
of the omple	Medical	and mariner states.		29d. Date signed	(Month, Day, Year)
	Ž	29b, Signature and title of certifier  O.C.M.E.		June 4, 2009	
		WMMM			
~ V		30. Name and address of person who completed cause of death (Item 23a)  Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201		
0	Ļ	Zabiolian Ali, W.B. 710010tan Western Signature			
Regi	State	STATE OF THE STATE		DCME	

			State of Maryla  State Registrar	•	artment of Health an ctificate of Death		iene 2009	18588
(3)	Physici	20	Decedent's Name (First, Middle, Last)			2. Date of Dear Month	Day Year	3. Time of Death
	Physici /Medic	al	4a. Facility Name (If not institution, give street and number)	<u> </u>	4b. City, Town, or Location of D	Ulo -	06 Z00	
)	Examin	ier	SDRING LIPELI HOSAI FALCENTELL		Sykesville		CARRO	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs 215-92-5352 18 M 2 F 45	s. last birthday) Yrs.	If Under 1 Year If Under 24  Months Days Hours	Hrs. 8. Date of Birth (Month, Day)	Year C	thplace (State or Foreign ountry) Shington
	-		Usual Residence of Decedent	ity, Town or Lo	cation			10d. Inside City Limits
	Maryia f shov led at	ō	,	Sykesvi				1 Yes 2 □ No
	or 28a-	irec	10e. Street and Number	- y 1.00 · 1	10f. Zip Code	1	10g. Citizen of What C	ountry?
	ath wit 23a c	rai	6655 Sykesville Road		21784		U.S.A.	orioon Indian
36	s after de ;; or Items caminer m	by Funeral Director	11. Marital Status  1 Mover Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in Armed Forces?  1  Yes 2 Mover Nover Nover Year or Dates:		Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F 1 □ Yes 2 ️ No Specify:	i? (Specify Yes or No- Puerto Rican, etc.)		
Maryland 21215-0036	be fled within 72 hours after death with the Maryland Hygiene. d other than "natural" or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed t	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usual Occupation kind of work done during most of DO NOT use retired)	f working	16b. Kind of Business	5/Industry
21.	filed witl Hygiene other tha	Com	4	Disa		Name (First, Middle,	Maiden Surnamo)	
and		9 Be	17. Father's Name (First, Middle, Last) Oliver Vroom		Mary D		Maiden Surname)	
ary	97	은	19a. Informant's Name/Relationship (Type. Print)	1	ng Address (Street and Number o			Zip Code)
	s 1 and 2 of Health a item 27 is other trai		Peter J. Vroom/Brother		Oakley Place, A	lexandria,	VA 22302 20c. Location - City o	
	a 0 = =		. To You	dent Gren		5/09/2009	Hanover, N	Maryland
Balt	permit. Pag Department Important: I any Injury o once.		21. Signature of Funeral Service Licensee  Laura C. Hardesty Mol		2. Name and Address of Facility 7522 Connelley			
	Physician		23a. Part1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	ath. Do not ent	er the mode of dying, such as ca	ardiac or respiratory and	rest,	Approximate Interval Between Onset and Death
6	/Medical Examiner		resulting in death)  Due to (or as a consci	equence of):	AR TERSON	11 FAF6		
ř	pe sit	iner	Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	quence of):	TENER!	110113		
ń	ate be executed hysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events c. Due to (or as a consorted by the consorte	equence of):	2 12 miles			
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o S	eath certific attending p for use as i	an/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fe		∃Ectopic pregnancy		23d. Date of d	
Б	at the deal by the att	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  1 ☐ Unknown		Other (specify)		Month	Day Year
ds, P	The law requires that the death certificate be executed to has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	þ	Part II. Other significant conditions contributing to death but not re	esulting in the u	nderlying cause given in Part i.		e. Did tobacco use contribute to the cause of death?  1 □ Yes 2 □ No 3 □ Probably 4 □ Onknown	
Records,	law req as been 2 shoul	Completed	opesity			24a. Was autop	prior to	autopsy findings available ocompletion of cause of
		Com				perfo 1□ Yes	rmed? death? 2☑No 1☐Ye	es 2 No
Vital	sician certifi irector	o Be	25. Was c. e referred to medical examiner?  1	ER/Outpatier	Othor	ing Home 5 Resid	ne) dence 6 ⊡Other (Sp	nacity)
on or	ding Phy h. After this funeral d	ion: To	27. Mann of Death 1 Natural 5 □ Pending (Month, Day Year)	28b. Time o		28d. Describe h	now injury occurred	iouny)
Division or	Atten ar deat ector; by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At building, etc. (Spe	home, farm, str cify)		28f. Location (S	tion (Street and Number or Rural Route Number, or Town, State)	
dr.	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical Co	29a. Certifier (Check only one)  Certifying Physician: To the best of my k  Check only one)  Medical Examiner: On the basis of exam and manner stated.					
4,	To the within 2 To the complet	Med	29b. Signature and little of certifier	Motre	Mu 29c. License number	200	29d. Date signed (Mo	nth, Day, Year)
)	2		Starapari MD	SPRINGE	CIERD WOOLS	300	6/6/00	1
			30. Name and address of person who completed cause of death (III	em 23a) (Type,	Print) SWADES!	1. Sykes	TIAN/ 10	21784
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  32. Pégistrar's Sig	nature.	harles			

DHMH 17 Rev 1/2001

09-04471 Leonard Vines Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 18589

		1- For State Certificate	of Death		eg. No.	
Physicia	n/	Decedent's Name (First, Middle,Last)		2. Date of Dea Month	Day Year	3. Time of Death 2331 hrs
ledical Examir		Leonard Vines	4b. City, Town, or Location of Death	June 4, 2	4c. County of De	
		4a. Facility Name (if not institution, give street and number)  Johns Hopkins Hospital	Baltimore		n/a	1
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs	. 8. Date of Bi	rth(MM/DD/YYYY) 9.	
Director	-	214 76 1818 1 <sub>x</sub> M <sub>2</sub> F 42	rs. Months Days Hours Min	Nov	17,1966	Country)
	<b>-</b>	Usual Residence of Decedent		1 110 4		
, any	Γ	10a. State 10b. County 10c. City, Town or Loc				10d. Inside City Limits 1 Yes 2 No
and f shov	ē L		imore		10g. Citizen of What (	21
Mary Mary	Director	10e. Street and Number	10f. Zip Code 21205		USA	Southly :
death with the Maryland or items 23a or 28a-f show must be notified at once,		815 N. Collington Ave.  11. Marital Status 12. Was Decedent Ever in U.S. 13. 13. 14. 14. 14. 14. 14. 14. 14. 14. 14. 14	Was Decedent of Hispanic Origin? ( S	necify Yes or N		merican Indian, Black,
ath wi	uneral	1 X Never Married 2 Married Armed Forces?	f Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, et	ic.
her de	Œ.	1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1	Yes 2 X No specify:		Specify:	Black
ours af atural camin	a P		tent's Usual Occupation (Give kind of most of working life. DO NOT use ret		16b. Kind of Busine	ess/Industry
6 72 ho	Complete	Elementary/Secondary (0-12) College (1-4 or 5+)	Chef	,	Baltim	noreAquarium
withir iene.	Ĕ	17. Father's Name (First, Middle, Last)		e (First Middle.	, Maiden Sumame)	.OI CIIqual I um
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Be C	Leonard G. Doles		ia Vin		
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once		19a. Informant's Name/Relationship (Type, Print )	ling Address (Street and Number or	Rural Route Nu	umber, City or Town, S	State, Zip Code)
MD nd 2 sho ulth and m 27 is aumati		Gloria Vines-Guthrie (mother)	815 N. Colling	gton A	ve Balt	o.Md. 21205
more, N Pages I and ent of Healti int: If item			oosition (Name of cemetery, other place)	Date	20c. Location - Ci	ty or Town, State
Pages ent of unt: I		4 Constion 5 Other Specify:		11,20	d9 Balto	,Md.
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner	- 1	2) Synature of Funeral Service Licensee	2. Name and Address of Facility Calvin B. Scru	ggs Fu	neral Ho	ome
	_/	23a. Part I. Enter the disease, or complications that caused the death Do not ent	1412 F. Presto	n St or respiratory a	Balto, Mo	Approximate Interval
Physician /Medical	/	failure. List only one cause on each line.				Between Onset and Death
caminer	İ	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	ntoxication and n	lethadol	ie use	
		Sequentially list conditions, b				
	iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
_	Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):				
executed an and al - transi		d. 220 27 280 f	,perME, g894 8.6.	ሰዓ ጥጥ		
iai e e	Medical	X UNPENDED AMENDED 23a,27,28a-1	,perms, go74 0.0.		Log - Date of the	
		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic pregi	nancy	23d. Date of de Month	Day Year
Box 68 death certiff the attending ed for use as	icial	past 12 months?  4 Pregnant at time of death 5	Other (Specify)			
BO) le deatl the att	Physician	1 Yes 2 No 9 Unknown g Unknown	Company of the Post I	23e Die	t tobacco use contribi	ute to the cause of death?
Records, P.O. Box 68: The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by P	Part II. Other significant conditions contributing to death but not resulting in	ne underlying cause given in Part I.			Probably 4 Unknown
ords, P.C v requires that s been signed should be dete	ted			24a. Wa		ere autopsy findings available
Cord law red has be	ple				rformed? de	or to completion of cause of ath?
tal Rec sian: The l certificate l ector, page	Completed		26.Place of Death (Chec		s 2 No 1	Yes 2 No
Division of Vital Records, Hospital or Attending Physician: The law required hours after death. Funeral Director: After this certificate has been stely filled in by the funeral director, page 2 should	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpa	lou.	sing Home 5	Residence 6	Other:
of V	10	27. Manner of Death 28a. Date of Injury 28b. Time			e how injury occurred	1
on of nding P tth. r: After	ion	1 Natural 5 Pending Fd 6 // / OQ Fd 1	1 Yes 2X No	unk		
Division tal or Attendi rs after death. at Director: /	fical	2 Accident 28e. Place of Injury - At home, farm,	street, factory, office building, etc.	28f. Locatio	n (Street and Number	or Rural Route Number, City Collington A
Divis	Certification:	4 Homicide determined (Specify) residence		Balti	more, MD	
r Hosp 24 ho r Func etely f		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death of one)  2 Medical Examiner: On the basis of examination and/or investigation.	occurred at the time, date and place, a	nd due to the c	ause(s) and manner a	e to the cause(s)
To the Hosp within 24 hc To the Fun completely	edical	and manner stated.	29c. License number	u at the time, di		d (Month, Day, Year)
	Σ	29b. Signature and title of certifier		CME	June 5, 200	
		Theodore M. For & Thym. D.	O,O,IVI.E.			)
or perd		30. Name and address of person who completed cause of death (Item 23a)  Theodore M. King, Jr., MD. Assistant Medical Examine	r 111 Penn Street, Baltimo	ore, MD 212	201	
	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
Regis		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	barke			
DHMH 17 Rev 1/2	2001	ORIG	NAL			

09-04505 Nataye Whitaker

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009	18590
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		1- For State Registrar	Certificate of Death	Reg. No.
Physicia	an/	1. Decedent's Name (First, Middle,Last)	L- 11-0	2. Date of Death Month Day Year 1055 hrs
Medical Exami		4a. Facility Name (if not/institution, give street and number)	4b. City, Town, or Location of Death	Julie 6, 2009
		St. Agnes Hospital	Baltimore	NA
Funeral		5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday) If Under 1 Year If Under 24Hr	- I Foreign
Director	J	220-83-6270 1 M 2XF	Yrs. 3 12 Hours Mir	Tehracy 25, 2009 maryland
*	ļ	Usual Residence of Decedent	Lio- Cit. Tours or Leasting	10d. Inside City Limits
ow any		10a. State 10b. County	Batimore	1 X Yes 2 No
Maryland 28a-f show d at once.	흲	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
he Ma or 28	Director	4820 Willistan Street	21229	USA
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once.		11. Marital Status 12. Was Decedent		Specify Yes or No-  No-  Nican, etc.)  14. Race - American Indian, Black, White, etc.
death or iter	Funeral		X No	,
s after iral",	à	Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade cor	1 Yes 2 No specify:  Inpleted) 16a. Decedent's Usual Occupation (Give kind of	Specify: African Amelium work done 16b. Kind of Business/Industry
2 hours at "natural	Completed	Elementary/Secondary (0-12) College (1-4 or	during most of working life. DO NOT use re	
5-0036 led within 72 Hygiene. t other than "	ğ	0 -	Infant.	INFANTO
5-0( Tled wi Hygier d other		17. Father's Name (First, Middle, Last)	18.Mother's Nam	ne (First, Middle, Maiden Surname)
21215-003 unid be filed within Mental Hygiene, marked other ti	To Be	Mortarus Whitaker  19a, Informant's Name/Relationship (Type, Print)	19b, Mailing Address (Street and Number or	Rural R - Number, City or Town, State, Zip Code)
and 2 shour lealth and N tem 27 is n traumatic	-1	Nortaeus Whitaker - fath	11/0.0 2 - 1	BAHIMORE MARYLAND 21229
re, M I and 2 Health Fitem 2		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from S	20b. Place of Disposition (Name of cemetery,	Date 20c. Location - Čity or Town, State
Pages nent of		4 Donation 5 Other Specify:	/ Nood laws	e 13 2009 Vibrdlawn MARY land
Baltimore, permit. Pages I ar Department of Hee Important: If ite	1	21. Signature of Funeral Service Lice See	22. Name and Address of Facility	LINERAL SERVICE MARYLAND 21229
Physician		23a, Part I. Enter the disease, or complications that cause	d the death. Do not enter the mode of dying, such as cardiac	or respiratory arrest, shock, or heart Approximate interval
/Medical		failure. List only one cause on each line.	explained death in infancy	Between Unset and
xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Sudden un  Due to (or as a constitution)		(2002)
	7	Sequentially list conditions, if any, leading to immediate b. Due to (or as a cons	sequence of):	
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated		
ecuted and transit	Exa	events resulting in death) Last  Due to (or as a cons	sequence of):	
ਗੂਜ਼ ex	ical	X UNPENDED AMENDED 23	a,27,28a-f,perME, g894 8/6/	709 TT
760, icate be exe	/Medical		ome of pregnancy	23d. Date of delivery
	_	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ectopic preg	nancy Month Day Year
Box 68 e death certif the attending	Physicia	1 Yes 2 No 9 Unknown 9 Unknown	5 Other (Specify)	
ords, P.O. Box 68' w requires that the death certif s been signed by the attending should be detached for use as	by Pł	Part II. Other significant conditions contributing to dea	eth but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 ✔ No 3 Probably 4 Unknown
S, P. uires th	q pa			24a. Was an 24b. Were autopsy findings available
ord aw req as bee 2 shou	Completed			autopsy prior to completion of cause of death?
Rec The la icate h	Som			1 Yes 2 No 1 Yes 2 No
ital Rec ician: The scertificate	Be	25. Was case referred to medical examiner?	26.Place of Death (Checulent 2 ✓ ER/Outpatient 3 DOA Other Number 1	ck only one) sing Home 5 Residence 6 Other:
ision of Vi Attending Physi or death ector: After this by the funeral dii	. To	1 V Yes 2 No 28a Date of In (Month, Day	Herit 2 V Errodipation 0 Bon 1 115	28d. Describe how injury occurred
OD C ending ath or: Af he fun	tion	Natural 5 Pending Fd 6/6/	1 Yes 2 X No	unk
Division of Vital Records, ral or Attending Physician: The law requirers and control of the properties	ifica	2 Accident Investigation 28e. Place of	Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number of Rural Route Number, City or Town, State) 4820 WILLISTON St
*	Certification	4 Homicide determined (Specify)		Baltimore, MD
I o the Fun	Medical	29a. Certifier 1 Certifying Physician: To the best of Check only one)  2 Medical Examiner: On the basis of ex	my knowledge, death occurred at the time, date and place, a amination and/or investigation, in my opinion, death occurre	ind due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause(s)
	Med	29b. Signature and title of certifier		29d. Date signed (Month, Day, Year)
		() M.	O.C.M.E.	June 7, 2009
		30. Name and address of person ho completed cause of		04004
		Jack Titus MD. Deputy Chief Medical		Z 1ZU I
S Regis	tate trar	11 IN 4 0 2000 1/2	rar's Signapre	

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** ARGA RET 2009 HIND /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Annapolis Anne Arundel Anne Arundel Medical Center Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 09/21/1923 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min 1 ☐ M 2 🔀 F 85 Maryland 217 14 0436 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show 1 ☐ Yes 2 No Funeral Director Anne Arundel Pasadena 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 21122 U.S.A. 487 Center St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 Tyes 2 No Specify: Specify: þ White 3 ₩ Widowed 4 □ Divorced than "natural", Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Anne Arundel County Elementary/Secondary (0-12) 1 2 College (1-4or 5+) n and Mental Hygiene. Dept of Public Wks Account Clerk 18. Mother's Name (First, Middle, Maiden Surname) Be ( 17. Father's Name (First, Middle, Last) Schlev Minnie May Gude ပ Raynor Guyton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pasadena, MD ZIIZZ 20c. Location - City or Town, State Department of Health a Important: If item 27 is any injury or other tra James G. Wooden, II - Son 487 Center St. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 06/11/09 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cem 21. Signature of Funeral Service Licensee GJ Gonce Funeral Home, I 21122 169 Riviera Dr. Pasadena, 23a. Part1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ROSPIRATORY Physician HOURS disease or condition resulting in death) /Medical Due to (or as a consequence of): PULMINARY DISPASE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ robably 4 🗌 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy nerform rmed? 2 No 1 ☐Yes 2 ☐ No 1 🗆 Yes Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 FR/Outpatient 3 DOA Certification: To 1 🗌 Inpatient 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar's Signature JUN 1 0 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

\* Registrar

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Records,

Division of Vital

State

31. Date filed (Month, Day, Year)

JUN 1 0 2009

82. Registrar's Signature

		1 - For State Registrar	e of Maryland		rtment of H		lental Hy	giene Reg. No. 2	009	185	93
		1. Decedent's Name (First, Middle, Last)					2. Date of De	eath Day	Voor	3. Time of Do	eath
Physici /Medic		Kenneth C Wilson					06	03	Year 2009	1353	M
Examin		4a. Facility Name (If not institution, give street and	number)		4b. City, Town, or	Location of Death		4c. Cou	inty of Death		
d.		Washington Adventist	Hospital		Takoma P				gomery		
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	ay, Year)	9. Birthp Cour	olace (State or I otry)	Foreign
Director		Usual Residence of Decedent	60	0 Yrs.			05/26	/1949		DC	
and		10a. State 10b. County	10c. City,	Town or Loc	ation				1	0d. Inside City	Limits
Mary -4 sh	ō	MD Prince George	I Hyro	ttsvil	10					1 X Yes 2	. □ No
r 28a	Director	10e. Street and Number	s liya	CCSVII	10f. Zip Code			10g. Citizen	of What Cour	ntry?	
be filed within 72 hours after death with the Maryland tal Hygiene. tal Hygiene. d other than "natural", or items 23a or 28a-f show event, I've Marical Examination must be notified a	<u>=</u>	4922 LaSalle Rd.			20782			USA			
death	Funeral	11 Marital Status 12. Was I	Decedent Ever in U.S.	. 13. V		ispanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No		Race - Americ		
after or ite		1 ☐ Never Married 2 ☐ Married 1 ☐ Y	d Forces? es 2.⊠M.No ,Give		Yes 2⊠No	Specify:	nican, etc.)		Black, White,		
ours iral",	d by		or Dates:			opecity.		Spi	Blac	ck	
72 h 'natu	Completed	15. Decedent's Education (Specify only highest grade complet	ed)	(Give I	ent's Usual Occupa kind of work done d	furing most of worki	ng	16b. Kind o	of Business/In	dustry	
vithin ane. than	E G		ge (1-4or 5+)		O NOT use retired,	)		Libont	on Dod	70	
iled v Hygie ther i		12th  17. Father's Name (First, Middle, Last)		car s	alesman	18. Mother's Name	/First Middle		on Dodg	3 <b>e</b>	
the familiar	Be					Bertha B			, iairio,		
2 should be filed we and Mental Hygie is marked other traumatic event, the	၉	Lacey Carl Wilson  19a. Informant's Name/Relationship (Type. Print)		10h Mailin	n Addrage (Street a	and Number or Rura			wn State Zir	Code)	
id 2 s lth ar 27 is trau		Rita M. Wilson/Daughter	. "			NW Washin				, 6666,	
permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any Injury or other traumatic once.		20a. Method of Disposition			sition (Name of latory or other place		ate		on - City or To	own, State	
mit. Pages 1 and 2 should be filled within 72 hours aft partiment of Health and Mental Hygiene. portant: If item 27 is marked other than "natural", or y Injury or other traumatic event, Item Marical Evantes.		1⊠ Burial 2 ☐ Cremation 3 ☐ Removal for	om State T				2000	IIo - h d		D.C.	
artme		4 □ Donation 5 □ Other (Specify)  21. Signature of Duneral Gervice Licensee	Roc	K Cree	Name and Address	ry  6/10/ ss of Facility Mar	2009 chall!		ngton		
Dep Imp any		Vall. Warsh	all			t NW Wash				iiie	
		23a. Part Enter the disease, or complications the	nat caused the death.							Approximate Interval Between	
Physician /Medical Examiner	iner	Sequentially list conditions.	e to (or as a conseque	Seles	is whice Co	ydiovase	ular	disc	are	Onset and De	eath
The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical Examine	triat intrated events	e to (or as a conseque	ence of):							
the death certific yy the attending p sched for use as	Physician/Me	in the past 12 months?	, outcome of pregnan live birth 2 □ Fetal ( Pregnant at time of de Jnknown	death 3□	Ectopic pregnancy	y		23d	. Date of deliv Month	ery Day Ye	ar
w requires that the desired speeds speed by the school of	ρ	Part II. Other significant conditions contributing	to death but not resul	ting in the ur	derlying cause give	en in Part I.		tobacco use		he cause of dea bably 4 □ Ur	
or Attending Physician: The law requires the after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be d	Completed						24a. Was auto peri 1 🗆 Yes	opsy formed?	4b. Were auto prior to co death? 1 □ Yes	opsy findings av ompletion of cau 2 □No	/ailable use of
slctan: certific irector,	Be (	25. Was case referred to dical examiner?			1	26. Place of Death					
Physl r this c ral dire	၉	1 Yes 2 → No Hospital:	1 ⊡Impatient 2 □ E			er: 4 Nursing Ho				fy)	
ding P. h. After t funera	Certification:	1 □ Natural 5 □ Pending	Date of Injury Month, Day, Year)	28b. Time of Injury	28c. Injury Work	₹?	28d. Describe	how injury o	courred		
tend leath tor: /	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2□No					
or At offer c Direct in by	rtifi	4 Homicide determined 28e. P	lace of Injury - At hon uilding, etc. (Specify)	ne, tarm, stre	eet, factory, office		281. Location City or To	(Street and Nown, State)	umber or Rur	al Route Numb	e <i>r</i> ,
Hospita 4 hours Funeral tely fille	ical	29a. Certifier (Check only one)  2  Medical Examiner: One and	he basis of examinati	on and/or inv	estigation, in my o	pinion, death occur	red at the time	e, date and pla	ace, and due t	to the cause(s)	
To the Hos within 24 h To the Fun completely	Med	29h Signature and title of certifier	manner stated.		29c Licence	e number		29d Date o	igned (Month,	Day, Year)	
5 ≥ E ⊗	8	200. Signature and title of certifier	, MD		) /) /	) / 4 / / .		/3 /	- Z	20, rour,	
			/		200	60100		06-	-6 2-	7	
6	2 77	29b. Signature and title of certifier  30. Name and address of person who completed  31. Uhirvisia  31. Date filed (Month, Day, Year)  JUN 1 0 2009	cause of death (Item	23a) (Type, I	Print) TAHN	nina le	MD MD	20903			
Sta	te	31. Date filed (Month, Day, Year)	2. Registrar's Signatu	ire La	de l						
Registr	ar	JUN 1 7009 A	ura p.	gara							

Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland by the permit of Health and Mental Hyglene.  Important: If item 27 marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is the standard of the permit of th	
Division of Vital Records, P.O. Box 68760,	ro the Hospital or Attending Physician: The law requires that the death certificate be executed to think 24 hours after death.  Think 24 hours after death.  Think 25 hours after death.	

**Funeral** Director

	1 - State Registrar	Cer	rtificate of Death	Reg. No	COOL CODS
cian	Decedent's Name (First, Middle, Last)     ZDENKA	WURMSE	R	2. Date of Death Month Date O8	3. Time of Death 3:35 A
lical iner	4a. Facility Name (If not institution, give street and 904 CRESTWICK ROAD		4b. City, Town, or Location of D		County of Death BALTIMORE
r	5. Social Security Number 220-62-0811 6. Sex 1 □ M 2 🔀 Usual Residence of Decedent	F Right (In yrs. last birthday) 83 Yrs.	if Under 1 Year If Under 24  Months Days Hours M	Hrs. 8. Date of Birth Min. 08/15/192!	9. Birthplace (State or Forei
	10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limi
Director	MD BALTIMORE	T0	WSON		1 □Yes 2 🕱 N
al Dire	10e. Street and Number 904 CRESTWICK ROAD		10f. Zip Code 21286	10g. C	itizen of What Country? USA
any injury or other traumatic event, the Medical Examiner cust be notified at once.  To Be Completed by Funeral Director	1 □ Never Married 2 M Married 1 □ Yes	ac 2MTMo	Was Decedent of Hispanic Origin if Yes, specify Cuban, Mexican, P 1 □Yes 2 🛣 No <i>Specify:</i>	? (Specify Yes or No- uerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE
	15. Decedent's Education (Specify only highest grade complet Elementary/Secondary (0-12) Collection	ed) (Give life, i	dent's Usual Occupation kind of work done during most of DO NOT use retired) PHYSICIAN		Kind of Business/Industry  MEDICAL
	17. Father's Name (First, Middle, Last) STANISLAV	KOUDELA	18. Mother's	Name (First, Middle, Maide	
	19a. Informant's Name/Relationship (Type. Print) LEON WURMSER / HUSBAN	I	ng Address (Street and Number of RESTWICK ROAD,		or Town, State, Zip Code) 21286
ury or our	20a. Method of Disposition 1 IX Burial 2 □ Cremation 3 □ Removal fr 4 □ Donation 5 □ Other (Specify)	om State 20b. Place of Dispo cemetery, crem BETH TFIL	natory or other place)	5/08/2009	BALTIMORE, MD
i di ka	21. Signature of/Funeral Service Licensee			OWN ROAD - PI	N & BROS., INC. KESVILLE, MD 21208
	resulting in death)	nat caused the death. Do not enton each line.  MC+AS+3+1C PA  e to (or as a consequence of):			Approximate Interval Between Onset and Death 7/2003
al Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c	e to (or as a consequence of):			
ıysician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year	
ed by Phy	Part II. Other significant conditions contributing	to death but not resulting in the u	nderlying cause given in Part I.		o use contribute to the cause of death
Completed				24a. Was an autopsy performed?	24b. Were autopsy findings availar prior to completion of cause death?  1 □ Yes 2 □ No
Be (	25. Was case referred to medical examiner?			Death (Check only one)	
on: To	27. Manner of Death 1 Natural 5 □ Pending (1)	1 ☐ Inpatient 2 ☐ ER/Outpatient Date of Injury Month, Day, Year)  28b. Time o Injury		28d. Describe how in	6 ☐ Other (Specify)  jury occurred
Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. P	and Number or Rural Route Number, ite)			
Medical C	(Check only 2 Medical Examiner: On t	o the best of my knowledge, deat he basis of examination and/or in manner stated.	th occurred at the time, date and ovestigation, in my opinion, death	place, and due to the cause occurred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
Me	29b. Signature and title of certifier	1D	29c. License number D 5 3 o 7		Oate signed (Month, Day, Year)  4nc 8, 200 9
	30. Name and addless of person who completed	cause of death (Item 23a) (Type, $SA$ $BG/H$ , $N$	Print) UD 2/23	/	
tate trar	31. Date filed (Month, Day, Year)  JUN 1 0 2009	cause of death (Item 23a) (Type, ST BG T, N 12. Registrar's Signature	facel		
/2001	JUNI U ZUUS				

			For State Registrar		State o	, maryta		rtificate of L			eg. No.2	109	18595
ſ	Physicia	an	1. Decedent's Name Blanche	e (First, Middle, La Kelly	ist)	Webst	er			2. Date of Deat Month June	3, 2009	9 Year	3. Time of Death 1:00A M
with the same of t	/Medic Examin		4a. Facility Name (/			ımber)		4b. City, Town, or Reistersto	Location of Death	-	4c. County of Death Baltimore		
Ī	Funeral Director		5. Social Security N 212–20–7913	umber 6.		7. Age (In yrs	s. last birthday) Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, March 28,	1924	9. Birth	nplace (State or Foreign untry) and
	fand ow	!	Usual Residence of 10a. State	Decedent 10b. County		10c. C	City, Town or Lo	ocation					10d. Inside City Limits
	a-fsh	ctor	Maryland	Baltimore		Re:	isterstow	n					1 □Yes No
	vith the	Dire	10e. Street and Nur					10f. Zip Code 21136		1	og. Citizen o	f What Cou	untry?
	death v	Funeral Director	1 Barn Gate	court	12. Was Dec	edent Ever in t	U.S. 13.	Was Decedent of H		pecify Yes or No-	14. R		rican Indian,
036	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Exeminer mest be natified at			ied 2 Married 4 Divorced	Armed For I ☐ Yes, G Year or I	orces? 2 <b>XX</b> No ive Dates:		1 □ Yes XX No	Specify:	o nicari, etc.)	Spec	WH.	ite
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ryla	hould by Men marke	မ	Henry David		(Time Print)		19h Maili	ng Address (Street				ın, State, Z	Zip Code)
Z	alth an 27 is I		Denise M We	·	(Type. I thin)	DTR	1	Gate Court		_		_	
altimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment mast be notified at once.		20a. Method of Dis 1 ☐ Burial X 4 ☐ Donation	position X Cremation 3 ☐ 5 ☐ Other (Spec	☐Removal from		eenMount	osition (Name of matory or other place Crematory	June		20c. Location  Baltimor	re, Ma	ryland
Balti	permit. Departm Importa any Inju		21 Sunature of Fu	ineral Service Lice	nsee /	akes	2	2. Name and Addre	ss of FacilitMitC 5500 York R				
E.	Physician		23a. Part 1. Enter t shock, or hea Immediate Cause disease or condition	ırt failure. List only (Final	polications that one cause on	each line.	ath. Do not en	ter the mode of dyir	ng, such as cardiad	or respiratory ar	rest,	11	Approximate Interval Between Onset and Death
زر	/Medical		resulting in death)	•	Due to	(or as a conse							2mo
	Examiner	e.	Sequentially list co	nditions,	D	(or as a conse		LEFT FOO	<b>ν</b> Τ				
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ot	<b>ling Phys</b> n. After this funeral di	<u>유</u>	27. Manner of Deat	th	28a. Date	e of Injury	28b. Time	of 28c. Inju	ry at	28d. Describe			
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sion	tending leath. tor: Afte the fune	cation	2 Accident	investigation	ho		Lama favor of	treat faston, office		29f Location /			lural Route Number
Division	il or Attending after death. Director: Afte d in by the fune	ertification			be 28e. Plac	ce of Injury - At ding, etc. (Spe		treet, factory, office		28f. Location (S City or Tox	vn, State)	mber or H	lural Route Number,
<ul> <li>Division of Vital Records,</li> </ul>	ospital or hours afte ineral Dir y filled in	dical Certification:	2 ☐ Accident 3 ☐ Suicide	investigation  6 Could not determine	28e. Place build b	ding, etc. (Spe	nowledge, dea	treet, factory, office  ath occurred at the tinvestigation, in my	ime, date and plac opinion, death occ	e, and due to the	vn, State) cause(s) and	d manner a	as stated.
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State RegistrarAVEND#7perFH5/27/09, EMW, McCo Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day 7:00a M **Physician** Catherine L. Parrish Brent 2009 May /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Laurel 15514 Plaid Drive If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 8182 Days 1 □ M 2 13 F 579-32-2344 June 10, 1926 Washington, D.C. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b, County 1- Yes 2 No MD Prince George's Laurel Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 15514 Plaid Drive 20707 United States Funeral 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify Specify: **Black** þ 3 ☐ Widowed 4 T Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) D.C. Public Schools Food Service Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Eva Wells 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7023 Woodstream Terrace, Lanham, MD 20706 19a. Informant's Name/Relationship (Type. Print) / daughter Sandra Carey 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 5/28/2009 Portsmouth, VA Belleville Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service Licenses 7400 Georgia Avenue, NW, Washington DC 20012 andre VAQU 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 months Brain Tumor Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Feta! death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 ☐ Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 🗷 No 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∏ Yes 2 No 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 🙀 Residence 6 ☐ Other (Specify) 1 Inpatient

**Physician** /Medical Examiner be executed burial-tran physician the

**Funeral** 

Director

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death with

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permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau

3altimore, Maryland 21215-0036

as esn for ed by the a signed t cate has been siç , page 2 should b Certification: To this After this funeral d Hospital or Attending n 24 hours af er deafin.
The Funeral Director Af

Division or Vital Records, P.O. Box 68760,

1 K Natural

2 Accident

3 ☐ Suicide

4 Homicide

5 ☐ Pending investigation

determined

28a. Date of Injury (Month, Day Year) 6 ☐ Could not be

and manner stated

2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical

State

Registrar

ompletely

within 2 the

29a. Certifier

D22755

5,22,09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Christine Delima, MD 7350 Van Dusen Road, suite #260, Laurel, MD 20707 Christine Delima, MD 31. Date filed (Month, Day, Year)

MAY 27



#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 8597 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MAY 21° 2009° ar 8:08 A M HARRY BODANSKY 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY BETHESDA SUBURBAN HOSPITAL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year MARCH 19) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) • 1919 GERMANY 1 X M 2 □ F 90 058-16-4046 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 XNo KENSINGTON MONTGOMERY MD 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 20895 9618 DEWMAR LANE 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 ☐ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Indus U.S. DEPARTMENT OF Elementary/Secondary (0-12) College (1-4or 5+) COMMERCE ECONOMIST 5+ 18. Mother's Name *(First, Middle, Maiden Surname)* ELSE WOLFF 17. Father's Name (First, Middle, Last) HUGO BODANSKY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10012 GAINSBOROUGH RD., POTOMAC, MD 20854 19a. Informant's Name/Relationship (Type. Print) ROBERT BODANSKY / SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition XX Burial 2 Cremation 3 ☐ Removal from £tate ADAS ISRAEL CEMETERY 05/24/2009 WASHINGTON, D.C. ther (Specify) 4 ☐ Dona ion 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 21. Sign tu 11800 NEW HAMPSHIRE AVE., SILVER SPRING, MD 20904 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a Part 1 Immediate Cause (Final HYOCANDIAL D disease or condition resulting in death) Due t (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter this dripting Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Fibrilation 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed 1 ☐ Yes 2 PNo

**Physician** /Medical Examiner

Department of Health Important: If Item 27 any injury or other trong.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show be rediffed at

Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. Int If Item 27 is marked other than "natural", or items 23a or ury or other traumatic event, If the 151 is a list but yo other traumatic event, If the 161 is a list but you will be a list of the straumatic event, If the 161 is a list but you other traumatic event, If the 161 is a list but with a list but you other traumatic event, If the 161 is a list but with a

Baltimore, Maryland 21215-0036

Director

Funeral

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Examine sician and burial-trans After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial Physician/Medical Completed by Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica completely filled in by the funeral director, Be Medical Certification: To

Division of Vital Records, P.O. Box 68760,

GODINSKY, HACKY GWIOG OSOS

9 Unknown

1 Natural

2 Accident

4 ☐ Homicide

3 ☐ Suicide

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death

5 Pending investigation

6 ☐ Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a. Certifier

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Leading the death occurred at the time, date and place, and due to the cause(s) and manner as stated. and manner stated. 29d. Date signed (Month, Day, Year)

npleted cause of death (Item 23a) (Type, Print)
11119 Rocknile Pika # 316 Rocknile, Hd 20 \$52

31. Date filed (Month, Day, Year) 7

State

Registrar

To the within 2.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 4:05 P 22, MAY 2009 BIDERMAN BENJAMIN Н. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ROCKVILLE MONTGOMERY CASEY HOUSE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthdav) 5. Social Security Number 6. Sex **Funeral** Min. Months Days Hours 1 ☑ M 2 □ F 78 SEPT. 11. 1930 **TEXAS** Director 450-42-9955 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Prodical Examinar must be notified at 1√ Yes 2 No Director MONTGOMERY BETHESDA MD. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20814 4925 BATTERY LA. #906 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

18 Yes 2 □ No 1955
If Yes, Give Year or Dates: 1975 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify. ۵ 3 X Widowed 4 ☐ Divorced WHITE Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than ' College (1-4or 5+) Elementary/Secondary (0-12) U.S. GOV'T. ARCHITECT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HARRIS BIDERMAN ANTTA SAM 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If item 27 is any Injury or other trau once. 7070 SADDLE DR., SYKESVILLE, MD. 21784 BELINDA BIDERMAN/DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-27-2009 CHAMBERS CREMATORY RIVERDALE, MD. 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A - Chambus MO0091 MM 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part 1. Enter the disease, or complication; that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 WEEKS ACUTE RENAL FAILURE **Physician** /Medical Due to (or as a consequence of) **Examiner** MONTHS METASTATIC BLADDER CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending PhysIclan: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Year Month Dav 5 Other (specify) ed by the a 1 ☐Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 sl autopsy performed? 1 □ Yes 2 No 1 ☐ Yes 2 | No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE Hospital: 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 27. Manner of Death 28c. Injury at Work? (Month, Day, Year) 5 ☐ Pending investigation Injury 1 X Natural n 24 hours after death.

e Funeral Director: Aft
bletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical within 24 hor To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number D47123 MAY 24, 2009 address of person who completed cause of death (Item 23a) (Type, Print) JOSEPH PUTHUMANA, M.D. 14246 MEADOW LAKE DR., GLENELG, MD. 21737 2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene ? Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 9:30P M May 18 2009 Adaline Lena /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Springbrook Adventist Nursing Home Silver Spring Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 H 8. Date of Birth (Month, Day, Year) yrs. last birthday) 98 Yrs. Social Security Number 6. Sex 7. Age (In **Funeral** Months Days Hours 177-01-0378 1 □ M 2 🛛 F July 21, 1910 Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits Maryland 10c. City, Town or Location 10h Count ral", or items 23a or 28a-f show Examiner must be notified at 1 XYes 2 No Directo Hvattsville Prince Georges Maryland 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 2 any hjury or other traumatic event, the Mudical Experient must be nonce. United States of America 20783 3402 Notre Dame Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 21 No Baltimore, Maryland 21215-0036 Specify. Speci@aucasian Completed by 3 ☑ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Ward Clerk Hospital 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dominica Pasiaqua ည Joseph Dominick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1558 Village Drive, Pittsburgh, PA 15237 Armand Joseph Dominick - Nephew 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 06/02/09 Brentwood, Maryland 21. Signature of Funeral Service Licersee 22. Name and Address of FacilityHines Rinaldi Funeral Home, Inc place 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1 Month **Physician** Stroke resulting in death) /Medical Due to (or as a consequence of): Examiner Years Atrial Fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23d. Date of delivery ves, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) □Yes 2K No signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Acute Renal Failure Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an Hypertension has autonsy 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? After Injury 5 ☐ Pending investigation 24 hours after death. e Funeral Director: Aft eletely filled in by the fun 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2

State Registrar

MAY 27 DHMH 17 Rev 1/2001

Ravi Passi, MD 31. Date filed (Month, Day, Year)

**ORIGINAL** 

D28656

15225 Shady Grove Road, Suite 208, Rockville, MD 20850

May 19, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

		•	1 - State Registrar			Certificate o	f Death	R	eg. No.				
	Physici	210	1. Decedent's Name (First, Middle, Las					h 2009 Year	3. Time of Death				
	/Medic		Joseph Anthor		ell	4h Chi Taua	and continued Depth	May 22,	4c. County of Deeth	10:00 рм			
	Examin	er	4a. Facility Name (If not institution, give Sanctuary at Ho						Montgor				
	Funeral		5. Social Security Number 6. S		(In yrs. last birth	day) If Under 1 Ye	ar II Under 24 Hrs.		9. Birth	place (State or Foreign			
b	Director		577-50-1665 Usual Residence of Decedent	M 20F 7:	l Y	Months Day	ys Hours Min.	Sept. 1		shington, D			
	yland		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits			
	a-f el	ctor	Maryland Montgo	omery	Si	lver Spri	ng			1 ☐ Yes 2 😿 No			
	라 다 6. 28	Director	10e. Street and Number			10f. Zip Cod	Θ	1	0g. Citizen of What Cou	untry?			
	ath w		10628 Eastwood			10.111 5 1 1	20901		USA 14. Race - Amer	rican Indian			
920	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural," or Items 23s or 28s-f show aumatic event, the Medical Evartifiat market multiple and	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:		If Yes, specify 0	of Hispanic Origin? (S Juban, Mexican, Puert No <i>Specify:</i>	o Rican, etc.)	Black, White				
ဝို	72 ho	eted	15. Decedent's Ed (Specify only highest gra		16a. [	Decedent's Usual Oc Give kind of work do	cupation ne during most of wo		16b. Kind of Business/I	ndustry			
121	iene. then "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5-		life. DO NOT use rei	ical Consu		Politics				
Maryland 21215-0036	d be filed ental Hygi ced other c event, I	To Be C	17. Father's Name (First, Middle, Last) Russell Barrett			Maiden Sumame) Urg							
ary	should Mind Mind Mind Mind Mind Mind Mind Min	1	19a. Informant's Name/Relationship (	Type, Print)	19b.	Mailing Address (Str	eet and Number or Ru	ıral Route Number	r, City or Town, State, Z	ip Code)			
Ž	and 2		Anne Barrett/Daug	ghter			-		er Spring,				
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic a <u>once</u> .		20a. Method of Disposition 1 □ Burial 2 ②*Cremation 3 □ * 4 □ Donation 5 □ Other (Specify		20b. Place of l cemetery Metro	20c. Location - City or a Alexandr:							
Balt	permit. Departn Imports any inju		21. Signature of Funeral Service Licen		00837				1 Home Inc. Silver Spi				
	Physician	23a. Part 1. Inter the disease, or complications that used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, ir heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  Metastatic Prostate Cancer with Metastasis to Bone & Bone											
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):										
	ted %.	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequence of								
68760,	ntilicate be executed ng physician and s as the burial-transit	sai Exar	that initiated events resulting in death) Last	Due to (or as a	Due to (or as a consequence of):								
68	titicati ig phy as the	Medicai											
O. Box	death ce e attendi d tor use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 Dectopic pregna 5 Other (specify			23d. Date ol deli Month	ivery Day Year			
۵.	that the ed by detac		Part II. Other significant conditions of	ontributing to death bu	t not resulting in	the underlying cause	given in Part I.	23e. Did to	bacco use contribute to	the cause of death?			
ds	uires n sign lld be	d by	Depression					1 □ Y	es 2 No 3 Pr	obably 4 Hunknown			
Division of Vital Records,	The law requires that the tee has been signed by the sage 2 should be detached.	Completed						24a. Was a	an 24b. Were au prior to comed? death?	itopsy findings available completion of cause of			
<u>e</u>								1 Yes		2 No			
<u> </u>	nysician: nis certifica director, p	Be c	25. Was case referred to medical examiner?	Hospital:	- A - FB10 :		04	ath (Check only or					
ō	Phys r this sral di	): To	1 ☐ Yes 2 ☐ No  27. Manner ol Death	28a. Date of Injur	v 28b. Ti	Jatient 3L DOA	4 Nursing F njury at Work?		ence 6 Other (Specow injury occurred	zify)			
sion	eath. or: After the tuner	cation	1 Accident 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	1	Year) In		Work? 1 □ Yes 2 □ No						
DIX	sal or Attens s after death at Director: ed in by the	Certification;	3 Suicide 6 Could not be determined	289. Place of Inju	e of Injury - At home, larm, street, lactory, office ing, etc. (Specify)  281. Location (Stree City or Town,					irai Houte Number,			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely tilled in by the tuneral director.	Medical (	29a. Certifier Certifying Ph (Check only 2 Medical Exertion)	ysician: To the best on niner: On the basis of and manner sta	examination and	death occurred at the for investigation, in n	e time, date and place ny opinion, death occi	e, and due to the curred at the time, c	ause(s) and manner as date and place, and due	stated. to the cause(s)			
	To the I within 2. To the I complet	Me	29b. Signature and title of certifier	100	× .	29c. Lic	ense number	_ 3	29d. Date signed (Month	h, Day, Year)			
}	2/		Jasneen	Hall	am	0	28595		5726/0				
			30. Name and address of person who TASNEEM LAK	completed cause of de	eath (Item 23a) (	S Smil	1+ ave	, Suite	203, BA	10 MI)			
				-									

DHMH 17 Rev 1/2001

State Registrar pares.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Mildred Boyer Baker 30 09 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CUMBERLAND ALLEGANY WMHS BRADDOCK CAMPUS Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Yea 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🛛 F 75 Aug. 4, 1933 Maryland Director 219-44-0528 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Maddal Eventher must be natified at Director 1 Tyes 2X No Frostburg Garrett 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21532 USA 2292 Finzel Rd. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify ģ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) within 72 Elementary/Secondary (0-12) College (1-4or 5+) 2 should be filed within and Mental Hygiene. Licensed Practical Nurse Hospital 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic ev Flossie Burdock Floyd Boyer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2292 Finzel Rd., Frostburg, MD James A. Baker/Husband Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. John's Cemetery June 1, 2009 Accident, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Licenses P.O. Box 275, Grantsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Conges? **Physician** years disease or condition resulting in death) /Medical Due to (or as consequence of) lugears Examiner there sclere Equentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the death certificate be executed burial-transit Exami and Due to (or as a consequence of) Box 68760, physician the burial Physician/Medical as IF FEMALE nse If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for Month Year Day 5 Other (specify) ned by the a detached for 1 ☐ Yes 2 ☐ No P.0. I signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗓 Unknown Completed been : Rulmaar 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate e Hospital or Attending Physician: 24 hours after death.
e Funeral Director: After this certificaletely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 ⊠Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 🗡 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 140 homas sla/ AVE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Dentho Registrar JUN 02

DHMH 17 Rev 1/2001

P.O. Box 68760. Division of Vital Records.

		1	For State Registrar		State o	f Mar	yland	d / Depa <i>Cei</i>	artmer rtificat	t of H e of L	lealth and D <i>eath</i>	d Menta		ene 2 (	009	186	02
	siciar edica	1	1. Decedent's Name (First Wilbur Jame										te of Death onth	B Day	0 <sup>Ye ar</sup>	3. Time of De. 1235	ath M
***	mine		4a. Facility Name ( <i>If not in</i> WMHS BR.		give street and nu				4b. City, Town, or Location of Death  CUMBERLAND					4c. County of Death ALLEGANY			
Fune Direc			5. Social Security Number  180-48-1216  1  N 2 F						lin. 8. Da Mar	te of Birth onth, Day, 15,	.964	9. Birthp Coul Penr	place (State or Fe ntry) nsylvani	oreign <b>a</b>			
laryland show			10a. State 10b.	County	mm	1		Town or Lo							1	10d. Inside City L	
h with the M 23a or 28a-		al Dilect	10e. Street and Number 12397 Natio				FLO	stburg	10f. Zip	Code L532			100	. Citizen of		ntry?	
Irs after dear	Joseph Parket	Dy ruile	11. Marital Status  1 □ Never Married 2  3 □ Widowed 4 □ D		12. Was Dec Armed For 1 1 Yes If Yes, Gi Year or D	rces? 2 No ve			Was Dece If Yes, spe 1 □ Yes		ispanic Origin? an, Mexican, Pu Specify:	(Specify Yeuerto Rican,	es or No- etc.)		ace - Americack, White,		
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.  It is marked other than "natural", or items 23a or 28a-f show and maryland.	t, and other states of	naheren	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)						kind of wo DO NOT u	rk done d se retired	during most of ( f)		No	Sb. Kind of E orth E nstitu	ranch	n Correc	tiona
be filed wital Hygie	Do Co	Ď.	12 Correctional Officier  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle,							Middle, Ma							
s 1 and 2 should be if Health and Ments Item 27 is marked	T	2	Wilbur Jame 19a. Informant's Name/Re			•			_		Elizab and Number or	Rural Rout	e Number, (			p Code)	
2 25 6		-	Brenda K. I		n/wife		20b. Pla	12397 ace of Dispo			l Pike,	Fros		MD 2		own, State	
permit. Pages 1 and Department of Heal Important: If item 2	o Amilia		1 ☑ Burial 2 ☐ Cren 4 ☐ Donation 5 ☐ C 21. Signature of Funeral S	ther (Sp	ecify)	State		ler Fa	amily	Cem	June ss of Facility	3, 20	09 G1	cants	ville	, MD	
Physici Depart Medic	an		23a. Part1. Enter the dissipance, or heart failur Immediate Cause (Final disease or condition resulting in death)		complications that only one cause on o	caused the each line.	ne death.	. Do not en	79 Mi. ter the mod	ller de of dyin	eral Ho St., G ng, such as can ANO/	rants diac or resp	P•A•, ville, iratory arres	P.O. MD 2	Box 2 21536	Approximate Interval Between Onset and Dea	
icate be executed when the physician and the purial-transit			Sequentially list conditions if any, leading to immedial cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	s, te	b	(or as a c	consequ	ence of):									
Physician: The law requires that the death certificate has been signed by the attending ral director name 2 should be detached for use as	ol/Maci		IF FEMALE: 23b. Was decedent pregn in the past 12 month 1 □Yes 2 □ No 9 □ Unknown	ant s?		birth 2 nant at ti	☐ Fetal	death 3[	□ Ectopic <sub>I</sub> □ Other ( <i>s</i>		у				ate of delive	very Day Yea	ar
w requires that been signed best	2	2									d tobacco use contribute to the cause of death? ]Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown						
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hysician: This certificate director pa	og of	ם	25. Was case referred to rexaminer? 1 ☐ Yes 2 ☑ No	medical	Hospital:	Inpatient	2 🗆 🛭	ER/Outpatie	nt 3 🗆 Do	Oth	26. Place of er: 4 ☐ Nursin	,	ck only one) □ Residen		ther (Spec	ify)	
Attending r death. ector: After by the fune			2 Accident	Pending investig  Could n determi	ation	nth, Day, \	Year)	28b. Time o Injury me, farm, str	М		yat k? Yes 2∐No	28f. Lo	escribe how ecation (Stream,	et and Nun		ral Route Numbe	τ,
the Hospital or hin 24 hours afte the Funeral Dir	J Icolbo				g Physician: To th Examiner: On the I and mar		xaminat										
To the veithin To the		INC	29b. Signature and title of	certifier	n ;	KI	n	na	29	c. Licens	e number	400	29	d. Date sign	ned (Month)	, Day, Year)	
	/ State	D	30. Name and address of 31. Date filed (Month, Day	Jo	MA	se of dea	11.5	1	Print)	NAI	HIGT	YAWA	LA	VALS	m	10219	02
Reg	jistrai	•	JUN	02	2009	Engage 4		B. A	aile								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	aryland		artmen <i>rtificat</i>			nd Me		giene 2	009	1860
76	Physic	an	Decedent's Name (First, Middle, Last)  Nola Joy Barclay								2. Date of De		Year	3. Time of Death
	/Medi		4a. Facility Name (If not institution, give		by Barc	lay	4h City	Town o	r Location of	Death		4c. County of Death		
	Examii	ier		1926 Cemetery	Pond		4b. City,	TOWII, O	Location of	Midi	and	40.000		llegany
			5. Social Security Number 6. S			st birthday)	If Under	1 Year	If Under 2		8. Date of Bir	th		place (State or Foreign
3,E	Funeral Director			7. Age (In yrs. last birthe			Months	Days	Hours	Min.	(Month, Da	y 02, 1923	Year) Country)	
	laryland show	or	10a. State 10b. County	11	10c. City, Town or L			Lonaconing						0d. Inside City Limits
	28a-f	Director	Maryland A  10e. Street and Number	llegany			105 7:-	Ondo	Lonac	oning		10a Citizon	of What Cour	2002
	with the period	ä		C4 4 2	00		10f. Zip	Code	216	20		rog. Citizen		SA
	s 23	gra		Street, Apt. 3		10.1	Mar Danie	11-611	215		· · · · · · · · · · · · · · · · · · ·	144		
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates:			<ul> <li>13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)</li> <li>1 ☐ Yes 2 ▼ No Specify:</li> </ul>					Race - Americ Black, White, ec <i>ify:</i>		
21215-0036	tura atura	Completed by	15. Decedent's Ed		-	16a. Deced	dent's Usua	al Occup	ation			16b. Kind o	of Business/In	
75	in 72 n "ne Mediy	plet	(Specify only highest gra	de completed)		(Give life. L	kind of wo	rk done se retired	during most d)	of workin	g			,
12	with iene than	E	Elementary/Secondary (0-12)	College (1-4or 5	p+)				Homema	aker			Н	lome
nd	should be filed within and Mental Hygiene. s marked other than tumatic event, the M	Be	17. Father's Name (First, Middle, Last)						18. Mother	's Name	ne (First, Middle, Maiden Surname)			
Maryland	2 should and Men is marke	은	19a. Informant's Name/Relationship (7	Ezra Kitzmiller  ppe. Print) 19b. Mailing Address (Street and Number or F				r or Rural	Daisy Luzier					
≥	1 and 2.8 Health ar em 27 Is other trau		Alexa Carter					1492		tery R	oad, Mid		ryland, 2	,
Baltimore,	permit. Pages 1 a Department of Hes Important: If Item any injury or othe		20a. Method of Disposition 1 ☐ Burial 2 ★ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	ice of Dispo metery, crer Cum	sition (Nar. natory or d berland	ther plac		Da	May 29, 2009		on - City or To Cumberlar	own, State nd, Maryland		
Balti	permit. Pag Department Important: I any injury o		Jan C. Mikje						ss of Facility ast Main				Kenzie Fr ng, MD 2	uneral Home F 1539
	Physician /Medical Examiner		23a. Part. Enter the disease, or compands, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line as Due to (or as	ne. 160 /	Met	er the mod	le of dyir	0			mrest,	•	Approximate Interval Between Onset and Death
68760,	ficate be executed physician and is the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as c		,								
P.O. Box 6	ath certi	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 12 No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3□	]Ectopic pi ] Other (sp		y			23d.	Date of deliver	ery Day Year
rds, P.	luires that the de signed by the a lid be detached to	by										Did tobacco use contribute to the cause of death?  1 □ Yes 2 12 No 3 □ Probably 4 □ Unknown		
Vital Records,	The law requir cate has been si page 2 should I	Completed									24a. Was auto perfe 1∐ Yes	psy ormed?	4b. Were auto prior to co death? 1 ☐ Yes	opsy findings available impletion of cause of
			25. Was case referred to medical						26. Place	of Death	(Check only		. 🗆 163	
>	Physiclan: this certificaral director, j	o Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	ant 2DE	R/Outpatien	t 3□ DC	Δ Oth	er.				Other (Special	ughters
	ding I. After fune	tion: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	iry 2	28b. Time of Injury		28c. Injui Wor		2		how injury oc		"O Home
5	il or Attending after death. I Director: Afte d in by the fune	Certification:	2 Accident 3 Suicide 4 Homicide		ury - At hom c. <i>(Specify)</i>	ne, farm, str			Ш		8f. Location ( City or To	Street and Ni wn, State)	umber or Run	al Route Number,
	Hospita 4 hours Funeral tely filled	Medical C	29a. Certifier (Check only one)	ysician: To the best niner: On the basis of and manner sta	f examination	ledge, deatl on and/or in	n occurred vestigation	at the ti	me, date and opinion, deat	d place, a th occurre	and due to the ed at the time	cause(s) and date and pla	d manner as s ace, and due t	stated. to the cause(s)
	To the within 2 To the complex	Me	29b. Signature and title of certifier	7			290	c. Licens	e number	. 10		29d. Date si	gned (Month,	Day, Year)

State Registrar

30. Name and ad less of person who correleted cause of death (Item 23a) (Type, Print) Agener

32. Registrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 9 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2:16 am Hnne Brandner 1200 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death (enter Garrett akland Kehab Oakland If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Sex () 1 □ M 2√() F Days Hours Min. 7/6/1924 MD 218-12-3926 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1√ Yes 2 No MD Garrett Oakland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 706 E. Alder Street 21550 U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Bookkeeper Accounting 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Agnes Kaufman Bortell Americus G. Bortell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 2 0 8 7 19a. Informant's Name/Relationship (Type, Print) Cece Bland/Niece 421 Christopher Ave., Apt 31, Gaithersburg, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/1/2009 Morgantown, WV Omega Crematory ture of Fun al Service Licensee 22. Name and Address of Facility Arthur H. Wright Funeral Home 105 Highland Avenue, Terra Alta, WV 26764 23a. Rart I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 1. 2day Immediate Cause (Final disease or condition resulting in death) Due to (or as consequence of): with loss of garareflax 16 CVA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a) a consequence of): fib Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Completed by Funeral

Be

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**Funeral** 

Director

with the Maryland

mit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla nartment of Health and Mental Hygiane. ortant: if Itam 27 is marked other than "natural", or iteme 23s or 28s-1 ehov injury or other traumatic event, Ita Modical Examination with the notified at

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

or Attending Physician:

To the !

Director:

within 24 hours after or To the Funeral Direct completely filled in by

Examine this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit Physician/Medical Completed by or death. ector: After this certifica by the funeral director, p Be Certification; To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 No 27. Manner of Death

1 Natural
2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28b. Time of

28a. Date of Injury (Month, Day Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier.

investigation

6 ☐ Could not be determined

5 Pending

29c. License number H0064705

St, Suite 1, Oakland

29d. Date signed (Month, Day, Year)

21550

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vorter N. Fourth Richan cA

2009

31. Date filed (Month, Day, Year) State JUN 01 Registrar

32. Registrar's Signature

DHMH 17 Rev 1/2001

09-04361 James Curtis Bach

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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			For State Certificate of Deat		Reg. No.		3. Time of Death		
Phys edical Exa		n/ 1	Decedent's Name (First, Middle,Last)  James Curtis Bach		2. Date of Death Month Day June 1, 2009	Year	1135 hrs		
				Town, or Location of Death	40	c. County of Deat Decil			
Fune Direc		5		ler 1 Year   If Under 24Hrs. hs   Days   Hours   Min.	8. Date of Birth(MM Dec. 26,	C	inthplace (State or Foreign ountry)		
	bw any	1	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  10aryland Cecil Perry	ville			10d. Inside City Limits 1 X Yes 2 No		
ne Maryland	23a or 25a-i snow any notified at once.			p Code 21903	10g. Ci	tizen of What Co			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	nust be not	ᅙ	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 14. Married Forces? 14. Yes 2 X No	lent of Hispanic Origin? (Speify Cuban, Mexican, Puerto F	ecify Yes or No- Rican, etc.)	White, etc.	erican Indian, Black, White		
2 hours after	"natural",	ted by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usua during most of w	2 X No specify:  Il Occupation (Give kind of working life. DO NOT use retire	ed) Ab	Kind of Busines	s/Industry Proving Ground		
21215-0036 and be filed within 72 Mental Hygiene.	other than	91	Four Years Chemical E		(First, Middle, Maide	n Surname)			
D 2121 should be fi	7 is marked natic event,	To Be		ss (Street and Number or R	Patricia K. Petersen  Number or Rural Route Number, City or Town, State, Zip Code)  Beach, Kewadin, Michigan 49648				
nore, MD ages 1 and 2 sho at of Health and	t: If item 2 other traum	- 1	20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  20b. Place of Disposition (N crematory or other place)	ame of cemetery, ce)	Date 200	Location - City West Che Pennsy	or Town, State		
Baltimore, permit Pages 1 at Department of He	Importan injury or		21. Signature of Funeral Service Licensee  Thomas M. Patterson, Sr. M00878  22. Name at Lee A.  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode follows. List only one cause on each line.						
Physic Med	cian lical iner		Immediate Cause (Final disease a. <u>Hypertensive atheroscle</u>				Approximate Interval Between Onset and Death		
		ier	or condition resulting in death)  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):  Due to (or as a consequence of):						
ited	d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   d.   Due to (or as a consequence of):  d.						
), be execu	ohysician and te burial - tra	Medical	X UNPENDED X AMENDED 23a, 27, perME, g89 Item, #21, perFH, C892, 6/	3 7/10/09 TT 11/09,WS		Ond Date of deli			
ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed death.	tending phys	sician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 5 Other (S	ath 3 Ectopic pregn		23d. Date of deli Month	Day Year		
P.O. Bo that the dea	gned by the attending p e detached for use as th	by Phys	1 Yes 2 No 9 Unknown g Unknown  Part II. Other significant conditions contributing to death but not resulting in the underly	ring cause given in Part I.	,		e to the cause of death?  Probably 4  Unknown		
Division of Vital Records, later Autening Physician: The law requires filer death.	been si	Completed			24a. Was an autopsy performe	d? prior	e autopsy findings available r to completion of cause of th? Yes 2 No		
= Re	certificate has ector, page 2 sl		25. Was case referred to medical	26.Place of Death (Check	k only one)				
Vita hysicia		To Be	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3	DOA Other Nursi	ing Home 5 Re	sidence 6	Other: Scene		
ion of tending P	tor: After this the funeral dir	ation:	27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day, Year)  28b. Time of Injury (Month, Day, Year)	1 Yes 2 No			or Rural Route Number, City		
` <b>∑</b>	neral Director: filled in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fact (Specify)		or Town, Stat	e) 			
Divi To the Hospital or within 24 hours afte	To the Funeral I	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred a (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.	t the time, date and place, and my opinion, death occurred 29c. License number	at the time, date an	d place, and due	to the cause(s)  (Month, Day, Year)		
		Σ	29b. Signature and title of certifier	O.C.M.E.		June 2, 2009			
			30. Name and address of person who completed cause of death (Item 23a)  Russell Alexander MD. Assistant Medical Examiner 111 Per	nn Street, Baltimore, I	MD 21201				
	S Regis		31. Date filed (Month, Day, Year) 32. Registrar's Signature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) BENNETT 2140 M LLIAN 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Anne Arundel Glen Burnie Marley Neck Health and Rehab Birthplace (State or Foreign
Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Months Days Hours 1 □ M 2 € F Yrs. 214-48-1091 85 Sept. 6, 1923 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Littleton Halifax Carolina 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 27850 138 Wharton Circle 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐Yes 2 If Yes, Give 2 No 1 Never Married 2 Married White 1 □Yes 2000No Specify: 3 X Widowed 4 ☐ Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Dept. of Labor 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Iva Mae Witt Wheatley E. Ward, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 138 Wharton Circle Littleton, NC Gail Eichner/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Durial 2 ☐ Cremation 3 ☐ Removal from State Glen Burnie, Maryland Glen Haven Mem. Park | 5/26/2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature eral Selvice License 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final les disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of):

**Physician** /Medical Examiner

**Physician** /Medical

**Examiner** 

10a. State

North

**Funeral** 

Director

28a-f shov

ral", or items 23a or 28a-f shov Examirer must be notified at

"natural"

permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical.

Director

Funeral

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Completed

Be

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed and I-transit burial-t

Examine been signed by the attending physician should be detached for use as the buria by Physician/Medical Completed cate has I page 2 s Be Certification: To n 24 hours after death.

e Funeral Director: Aletely filled in by the fi

Division of Vital Records, P.O. Box 68760,

resulting in death) Last	Due to (or as a consequence of):	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1  Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)	23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknow
		24a. Was an autopsy performed? 1 □ Yes 2 □ No 1 □ Yes 2 □ No
25. Was case referred to medical	26. Place of Death (	Check only one)
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home	5 Residence 6 Other (Specify)
27. Manner of Death  1. Natural 5 Pending 2 Accident investigatio	(Month, Day, Year) Injury Work?	d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be determined		f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Certifying P	hysician: To the best of my knowledge, death occurred at the time, date and place, an	nd due to the cause(s) and manner as stated.

Registrar

edical

31. Date filed (Month, Day, Year) MAY 26

Name and address of person

32. Registrar's Signature

DEFENSE /tranway ANNAPOUSMY

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mapnes stated.

29c. License number

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

the

23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2310 M **Physician** BADEAUS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Annapolis Anne Arundel Arbor at Baywoods If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Min. Months Days Hours Louisiana 1 M 2 □ F 93 May 19, 467-05-0237 Yrs. Ĩ916 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.
is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County traumatic event, the Madical Examiner must be notified at Annapolis Maryland Anne Arundel ty⊟Yes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21403 7101 Bay Front Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 X Yes 2 □ No 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1940–46 1 ☐ Ye's 21 No Specify. White à 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrician Electrical 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethel Mary Clements Leonce Badeaux ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traum once. 70471 23636 Robert Road Mandeville, Louisiana Linda Derby/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore Crematory 5/24/2009 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 TU 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final eard Physician disease or condition resulting in death) /Medical Due to (orus a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician; The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical the use as 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year for in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ğ 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 26. Place of Death (Check only one)

Other: 4 □ Nursing Home 5 □ Residence 6 ☑ Other (Specify) Hospital: BAYWUN 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After this funeral o 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Hospital or Attending Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier edical and manner stated within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie Name and address of person who completed cause of death (Item 23a) (Type\_P EFENSE HIGHWAY

State Registrar 31. Date filed (Month, Day, Year) MAY 26

DHMH 17 Rev 1/2001

. Registrar's Signature

09-03971

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2009 18608 Thomas J. Castonguay State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Time of Death Physician/ 1. Decedent's Name (First, Middle, Last) Month Day May 18, 2009 1900 hrs Medical Examiner Thomas Joseph Castonguay 4a. Facility Name (if not institution, give street and number)
3529 Dartmoore Lane 4b. City, Town, or Location of Death c. County of Death Montgomery Olney If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign District 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Days Hours Director June 23,1948 of columbia 579-64-8747 1 X M 2 60 Yrs Usual Residence of Decedent 10d. Inside City Limits any 10a. State 10c. City, Town or Location 1 Yes 2 X No s 23a or 28a-f show e notified at once. or 28a-f show MD Montgomery 01ney . Pages 1 and 2 should be filed within 72 hours after death with the Maryland timent of Health and Mental Hygiene.

Tant: If item 27 is marked offer than "natural", or items 23a or 28a-f sho Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3529 Dartmoor Lane 20832 United States Funeral 14. Race - American Indian, Black, 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Was Decedent Ever in U.S. tranmatic event, the Medical Examiner must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married 1 X Yes 2 f Yes, Give Year 1970-71 Specify: White Divorced Yes 2 X No specify ğ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government timore, MD 21215-0036 4 Grants Specialist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Bernard Castonguay Catherine Elizabeth McGuire 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) James Castonguay/Brother 18808 Sunset Hills Court, Gaithersburg, MD 20879 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition Metropolitan Crematory Burial 2 X Cremation 3 Removal from State May 23, Alexandria,Virginia 2009 Donation 5 Other Specify: 22. Name and Address or real HOme, 10 Gaithersburg, 21. Signature of Funeral Service License East Deer Park Drive, MD 20877 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Physician Between Onset and /Medical Death a Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease **xaminer** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and - transit Physician/Medical X UNPENDED **AMENDED** attending physician for use as the burial #4aperME BMW, MoCo /27/09 Division of Vital Records, P.O. Box 68760 23d. Date of delivery IF FEMALE: If yes, outcome of preg 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year icate has been signed by the attending page 2 should be detached for use as t Live birth Fetal death Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 No 3 Probably 4 V Unknown Diabetes Mellitus Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has performed? death? ✓ Yes 2 1 🗸 2 No • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certifi 25. Was case referred to medica 26.Place of Death (Check only one) Be examiner? Other<sub>4</sub> Hospital: Residence 6 V Other: Scene DOA Nursing Home 5 Inpatient 2 ER/Outpatient 3 1 ✔ Yes 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification: 1 V Natura Yes 2 Pending filled in by the 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide determined (Specify) Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29h Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 19, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Patricia Aronica-Pollak MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year, Registrar's Signature State

DHMH 17 Rev 1/2001 **OCME 2006** 

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**OCME** 

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 23, 5:29 P M May Phillip Edward Cook /Medical 4c. County of Death 4h. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Laurel Laurel Regional Hospital 8. Date of Birth (Month, Day, You Sept 28, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Min. Months Days Hours Indiana 1944 311-48-5943 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Exertiting out to notified at 1 XYes 2 No Director West Baden Spring IN Orange 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 72 hours after death with **USA** 47469 797 N. Habig Road #6 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No If Yes, Give Year or Dates: 1967–71 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 3 ☐ Widowed 4 █ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Factory Factory Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any linity or other traumatic event once. Be Anna Margaret Thomas Cecil H Cook, Jr. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11812 Bristolwood Terrace Laurel, MD 20708 Cecil H Cook III/brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State W. Arundel Crematory 05/27/09 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) Goiling Thomes Cremation Service P.O. Box 784 21. Signature of Funeral Service Licer MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardio-respiratory Arrest **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Aortic Stenosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Diabetes Mellitus and burial-trar Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day 5 Other (specify) □Yes 2□No P.O. certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ₽ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 1 ☐ Yes 2 No 1 ☐ Yes after death.

Director: After this certific 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1XYes 2 □ No 1 ☐ Inpatient 2 KER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death (Month, Day, Year) 1 XNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 24 hours af Funeral Dietely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical within 24 ho

To the Fune

completely f 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier npleted cause of death (Item 23a) (Type, Print) 30. Name and address of person wh 5X1 Sukhjit Sidhu, M.W. 7300 Van Dusen Rd. Laurel, MD 20707 31. Date filed (Month, Day, Yea 32. Registrar's Signature State 2009 parket \* Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2009 **Physician** 5:41 a M 30, May Carroll Nancy Halfpap /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Clinton Southern Maryland Hospital 8. Date of Birth (Month, Day, )
June 20, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🖾 F Yrs. Maryland Ĩ952 56 412-56-8520 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Modical Evandor in ust be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 24 No Director Waldorf Charles Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20601 14804 Woodville Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐Yes 2 X No If Yes, Give 1 ☐ Never Married 2X Married 1 □Yes 2K No Specify. 2 White 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bage1men Helena Arthur Halfpap မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14804 Woodville Rd., Waldorf, MD 20601 Joseph E. Carroll, III/Spouse Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 5/31/2009 Charlotte Hall, MD Brinsfield-Echols 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Brinsfield-Echols Funeral Home, P.A 30195 Three Notch Rd., Charlotte Hall, MD 20622 Approximate Interval Between Onset and Death 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SUPSIS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Clostridium d. ff. c. 4 colits Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Non Insulin dopocut Dinbutes Malling attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical 23d. Date of delivery ves, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 → O 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an director, page 2: performed? 1 ☐Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1√ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 2 No Certification: To funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

requires that the death certificate be executed Box 68760 P.0. Records, Division of Vital To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After

has

certificate

this

After

Baltimore, Maryland 21215-0036

State Registrar

completely

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Civingston Rood Fort Waskington unaryland.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

		-	For State Registrar	State of N	/larylan		artment of I		nd Mental H	ygiene Reg. No.	/ 1111 4	18611
			1. Decedent's Name (First, Middle, La.	st)					2. Date of D	eath Day	Year	3. Time of Death
	Physici: /Medic Examin	al	George Francis  4a. Facility Name (If not institution, giv		er)		4b. City, Town, o	or Location of	May 2		09 County of Death	10:43 a.m.
4	Xaiiiii	<u>.</u>	45822 North Potes	t Court			Californ		411 (		. Mary's	
	Funeral		5. Social Security Number 6. S	8ex 7./ 1XIM 2□ F	Age (In yrs. I	la <i>st birthday)</i> Yrs.	If Under 1 Year Months Days		Min. 8. Date of E (Month, I	Day, Year)	9. Birtin Cour Mary	place (State or Foreign ntry)
	Director		Usual Residence of Decedent		69				00/22/	1939		
	yland now		10a. State 10b. County		10c. City	y, Town or Lo	cation				1	10d. Inside City Limits 1 ☐ Yes 2 X No
	sa-fs	Director	Maryland St. Mary	¹s	Ca1	iforni				T	()411 10-11	
	ith th		10e. Street and Number				10f. Zip Code			"	izen of What Cou	
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Madical Exeminat must be notified at	Funeral	45822 North Potea	t Court	nt Ever in II	S 13	20619 Was Decedent of	Hispanic Orio	nin? (Specify Yes or I		ed State	ican Indian,
<b>'</b> O	fter de ritem ilner	표	<ul><li>11. Marital Status</li><li>1 X Never Married 2 ☐ Married</li></ul>	Armed Force	s?				gin? (Specify Yes or I , Puerto Rican, etc.)	Ì	Black, White,	etc.
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d 2	filed withi Hygiene. other thar		17. Father's Name (First, Middle, Last	· · · · · · · · · · · · · · · · · · ·		00000	424	18. Mothe	r's Name (First, Midd			
an	Suld be f Mental arked o	To Be	George Johnson					Marie	Chase			
Maryland	2 should and Men is marke raumatic		19a. Informant's Name/Relationship	(Type. Print)		19b. Maili	ng Address (Stree	et and Numbe	er or Rural Route Nur	nber, City o	or Town, State, Zi	ip Code)
Σ,	1 and 2 Health a tem 27 is		Marie Butler/Daug	hter	T				St. Inig	oes,	MD 2068 ocation - City or T	
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinat must be notified at once.		4 □ Donation 5 □ Other (Special		St.		Claver 2. Name and Add					, Maryland
Ba	permit. Pages 1 and 2 Department of Health 8 Important; If item 27 is any Injury or other tra <u>once</u> .			sfield, J		0052 2	2955_Ho1	1ywood	Road, Le	nard		20650
	Physician		23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition	nplications that cause one cause on each	n line.		ter the mode of dy	i	1- / -	y arrest, Euke	mia	Approximate interval Between Onset and Death
and the second	/Medical Examiner	ı	resulting in death)	Due to (or	as a conseq							_1
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oʻ	ite be executed ysician and ne burial-transit		resulting in death) Last	Due to (or	as a conseq	juence of):						
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x 68	The law requires that the death certificate be executed at has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE:	23c. If yes, outco	mo of prean	ancv					22d Data of dali	ivory
Вох	eath c attend for us	ian/	23b. Was decedent pregnant in the past 12 months?	1 🗆 Live bir	th 2 Feta nt at time of	al death 3	☐ Ectopic pregna ☐ Other (specify)				23d. Date of deli Month	Day Year
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٠, ص	e law requires that the de has been signed by the e 2 should be detached	y P	Part II. Other significant conditions			_		given in Part I				the cause of death?
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E E	t The cate h	5							1 □ Ye	erformed? s 2 N	death? o 1 ☐ Yes	2 □ No
Vita	Physician; r this certific ral director, I	Be	25. Was case referred to medical examiner?	Hospital:				)than	e of Death (Check or		0.000	-76.4
of	Phys r this ral di	<u>اد</u>	1 Yes 2 No 27. Manner of Death	28a. Date of	Injury	28b. Time	of 28c. In	4 🗀 NI	ursing Home 5 🔀 F		ury occurred	city)
lon	Attending or death. ector: After by the funer	ţio	Natural 5 ☐ Pending 2 ☐ Accident investigation		Day, Year)	Injury		lork? □Yes 2□	No			
Division of Vital		Certification: To	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	_   ∠oe. Flace 0	f Injury - At h	nome, farm, s	treet, factory, offic	e	28f. Locatio City or	n (Street a Town, Stat	and Number or Ru te)	ural Route Number,
ā	ital or irs afte ral Dir	Ç								the course	(a) and manner as	e etated
	Hospital 24 hours a Funeral I	Medical	29a. Certifier Certifying F (Check only one) 2 Medical Ex	hysician: To the bas aminer: On the bas and manne	is of examin	iowledge, dea ation and/or	ath occurred at the investigation, in m	y opinion, de	nd place, and due to ath occurred at the ti	me, date ar	nd place, and due	to the cause(s)
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	Jm		30. Name and address of person wh	o completed cause	of death (Ite	m 23a) (Type						
	7)		Amish Jha		3 7 gistrar's Sign		U Mirg	on t	-u, proc	lon,	CANIL E	MD 26659
	St Regist	ate rar	31. Date filed (Month, Day, Year)		giotiai o oigri	L	Ch.					

DHMH 17 Rev 1/2001

ORIGINAL

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			Decedent's Name (First, Middle, Last)				2. Date of Death Month	n Day	3. Time of Death
	Physicia /Medic		John Francis Carroll				May 30,	2009	9:03 p.m.
	Examin		4a. Facility Name (If not institution, give street and numb	er)	4b. City, Town, or	Location of Death		4c. County	
10 mil			49523 Carroll Road	Age (In yrs. last birthday)	Lexington	n Park If Under 24 Hrs.	8. Date of Birth	St. Ma	Y S  9. Birthplace (State or Foreign
	Funeral Director		5. Social Security Number  212-54-2493  6. Sex 1 □ M 2 □ F	57	Months Days	Hours Min.	01/06/19	Year)	Country) Maryland
			Usual Residence of Decedent				01/00/1		
	ryland how	_	10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	e Ma	Director	Maryland St. Mary's	Lexington			1.0	Og. Citizen of V	
3	a or 2		10e. Street and Number		10f. Zip Code				
-	sath v	Funeral	49523 Carroll Road	nt Ever in U.S. 13. V	20653 Was Decedent of His	spanic Origin? (Sp	ecify Yes or No-		States ce - American Indian,
	riter de	핊	11. Marital Status  1 ☐ Never Married  2 ☒ Married  1 ☒ Yes 2  If Yes, Give	s?	If Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)		ck, White, etc.
25	al",o	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Date	es:	1∐Yes 2∭XNo	Specify:		Specify	White
ה ה	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give	dent's Usual Occupa kind of work done d DO NOT use retired,	ation Juring most of work		16b. Kind of B	usiness/Industry
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V .	is filed within 72 hours after death with the Maryland Afgiene. other then "natural", or items 23a or 28a-f show vent, It e Medical Examinations to retified at	ပ္ပိ	12   17. Father's Name (First, Middle, Last)	Alici	alt Manag	18. Mother's Nam			
מ ב	d be i ental ced o	To Be	Charles Carroll			Jane Sau	nders		
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Σ :	alth a 27 is		Helen Rebecca Carroll/Wif	e 49523	Carrol1	Road, Le	xington	Park,	MD 20653
5	es 1 a of He of He ritem		20a. Method of Disposition 1 ☐ Burial 2 ★Cremation 3 ☐ Removal from Sta	20b. Place of Dispo cemetery, crer	osition (Name of matory or other place	e)	Date	20c. Location	- City or Town, State
allimor	Page ment ant: II ury o		4 □ Donation 5 □ Other (Specify)	Brinsfiel	d-Echols	Cre 06/02	2/2009	harlot	te Hall, MD
<u>ק</u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiens. The Important: if item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, If a Modical Examinating the righted at once.		21. Signature of Juneral Service Licensee						11 Home, P.A.
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	hysician /Medical		resulting in death)	dvancled s	stage h	ung car	) cer		
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Ď	be executed ician and burial-transit		resulting in death) Last Due to (or	as a consequence of):					
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POX	atteno for us	Physician/Med	in the past 12 months?	th 2 Fetal death 3	☐ Ectopic pregnanc	у			onth Day Year
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ecords	aw ren Is bee 2 shoi	Completed			<u> </u>		24a. Was a		. Were autopsy findings available prior to completion of cause of
ř	The I	mo					perfor	med? 2 No	death? 1 ☐ Yes 2 ☐ No
VItal	sian: ertifica ctor, p	Be	25. Was case referred to medical examiner?				th (Check only or	ne)	· · · ·
0	ding Physician: The law requires that the done the control of the After this certificate has been signed by the funeral director, page 2 should be detached the control of	은	1 Yes 2 No Hospital: 1 In	patient 2 ER/Outpatie		4 Li Nursing F	ome 5 A Resid		
ב	ling P	ion:	I Matural 5 Life inding	Injury 28b. Time of Injury	Worl	ryat k?  Yes 2∐No	28d. Describe h	ow injury occu	med
VISION	ttend death stor: / the f	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e. Place of	f Injury - At home, farm, st	- Viv	1162 2 1110	28f. Location (S	Street and Num	nber or Rural Route Number,
	lor A after Direction by	Certification:	4 Homicide determined building	g, etc. (Specify)	,		City or Tow	n, State)	
_	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director; to the f		29a. Certifier 1 Certifying Physician: To the t	pest of my knowledge, dea	th occurred at the ti	ime, date and place	e, and due to the	cause(s) and r	manner as stated.
	he Hc in 24 i he Fu pleteli	edical	(Check only one) 2 Medical Examiner: On the barrance	sis of examination and/or i er stated.	nvestigation, in my o	opinion, death occi			
	Vith To th	M	29b. Signature and title of certifier		29c. Licens	se number		29d. Date sign	ned (Month, Day, Year)
	1		16161033111	1	1000	77265		06-0	71-07
	S		30. Name and address of person who completed cause	. 0 m/	Kout RD	LEONAR	DIOWON	MD.	2,650
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chael Campbell	State of Maryland / Department of Health and Mental Hy	/gierie	20	UJ	8
1- For State	Certificate of Death	Reg. No.		· · ·	Death
Registrar	(F)	2. Date of Death	Veer	3. Time of	Death

Steven Michael C			e of Maryland /	Departi	ment of incate of i	Health	and	Mental F	Hygiene		2	009	100
	Re	For State gistrar		Certii	icate or	Dealii			2. Date of		Veen		ne of Death
Physicia		Decedent's Name (First, Middle,L		11					Month	31, 2009	Year		32 hrs
Medical Examin	161	Steven Michae  a. Facility Name (if not institution)	e 1 Campbe give street and number)	<u></u>	41	c. City, Tov	vn, or Lo	cation of Dea	ath	1	C. County of E	eath	
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		216-25-5043 1 1 sual Residence of Decedent										10d.	Inside City Limits
any	_	0a. State 10b. County		10c. City, To	own or Location	on						1	Yes 2 X No
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or 28	Director	48050 <u>Galley Wa</u>	Unit 10/			206	53				ited St	ates	dian Block
Baltimore, MD 21215-0036  permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I filem 27 is narked other than "unstural", or items 23a or 28a-f show injury or other tranmatic event, the Medical Examiner must be notified at once.	la l	1. Marital Status	<ol><li>12. Was Deceden</li></ol>	t Ever in U.S.	13. Wa	c Deceden	t of Hist	anic Origin? ( Mexican, Pue	Specify Ye	es or No- etc.)	14. Race - White,		ndian, Black,
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her de	F		rced If Yes, Give Year			Yes 2			of work don	16t	Specify: . Kind of Busi	White iness/Indust	
urs af	<b>a</b>	15. Decedent's Education (Speci	fy only highest grade co	mpleted)	16a. Deceder during m	it's Usual C lost of work	occupations of the contract of	on (Give kind DO NOT use	retired)	le l'or	, rand or Edo		.,
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15-0036 Ted within 77 Hygiene. I other than	ပိ	17. Father's Name (First, Middle, I											
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21 nould I nd Mer is man	유									c Cal	iforni	a. MD	20619
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alti mit partm ports		21. Signature of Funeral Service	icensee	-)		Name and	Address	B 1	rinsf	ield F	uneral	. Home	20650 _
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Division of Vital Records, rat or Attending Physician: The law requirers after death.	Completed									autops:	ned?	death?	2 \ \ No
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isic Atte	i by t	2 Accident Inv	uld not be	of Injury - At	home, farm, s	street, facto	ory, offic	e building, etc					alifornia, MD
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lospi 4 hou	ely fil		Physician: To the best	of my knowle	edge, death o	ccurred at	the time	, date and pla	ice, and due	e to the cause e time date a	e(s) and manr and place, and	er as stated d due to the	u. : cause(s)
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director: After this certificate has been signed by the attending physician and	completely	one) 2 Medical Ex	Physician: To the best kaminer: On the basis of and manner sta	f examination	and/or inves	ligation, iii	Thy Opin		ourreu at th	o unio, date t			th, Day, Year)
To To	9	29b. Signature and title of certi		- /				ense number					, 20,, 100/
			Q 211 /	16	_		Ο.	C.M.E.			June 1, 2		
		30. Name and address of pers	on who completed caus	e of death (Ite	em 23a)								
AC		Jack Titus MD. D	eputy Chief Medic	al Examin	er 111	Penn St	reet, E	Baltimore,	MD 2120	)1 			
	C to			gistrar's Sign		- 41	7						
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 05 **Physician** 053U M CHILDS RGINIA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1505 Broadneck Place, #301 Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Ye) Oct. 20, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Vear Months Days 1 M 2 Z F Oct. 578-24-8548 84 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Wedical Evantume rust by mortified at Maryland 1 □Yes 2 No Anne Arundel Director Annapolis 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1505 Broadneck Place, #301 21409 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ∏Yes 2 TNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐Yes 2 📆 🗖 o Specify. ģ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Office Manager YWCA 2 should be filed what and Mental Hygie 15 Is marked other the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Francis O. White Ruth Tucker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s.
Department of Health ar
Important: If item 27 Is 1
any injury or other trans Mark Childs/son 1602 St. Margaret's Road Annapolis, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Baltimore Crematory 5/25/2009 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature deral S 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final acute on chom HEART TAILUNE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ORTIC MUNTHS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed and burial-trai Due to (or as a consequence of): O. Box 68760, the attending physician hed for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown ۵. signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 After thi funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 □Yes 2 □ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d Pate signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar

State

31. Date filed (Month, Day, Year)

MAY 26 2009

32. Regist

32. Registrar's Signature

on pleted cause of death (Item 23a) (Type, Prin

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) РМ 3:45 May 25, 2009 Katherine Berry Clagett 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Prince George's 3610 Ritchie-Marlboro Road Upper Marlboro If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Days Hours 89 July 7, Maryland 1919 579-18-0208 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 X No Upper Marlboro Maryland Prince George's 10g. Citizen of What Country? 10e. Street and Number 20772 USA 3610 Ritchie-Marlboro Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Bowie James Berry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12001 Old Marlboro Pike, Upper Marlboro, MD 20772 Kathy Carr / Daughter 20c. Location - City or Town, State Date Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 5/26/2009 Alexandria, Virginia Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 4739 Baltimore Avenue RAY Rugeris Gasch's Funeral Home, PA Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final a. Hypoxemia disease or condition resulting in death) Due to (or as a consequence of): Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 🖾 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Artery Disease 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Cardiac Arrhythmia 24a. Was an perform 1 □Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

28a-f show

Director

Funeral

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7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the "Medical Exportment is untibuted.

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attending physician and for use as the burial-transit been signed by the should be detached cate has page 2 s certificate director, this

Examine Physician/Medical Completed by Be

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, ours after death.
neral Director: After this
y filled in by the funeral di within 24 hours a

To the Funeral I

completely filled

P.O. Box 68760.

State

Certification: To

Medical

Eresseys

5 Pending investigation

6 ☐ Could not be

determined

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D25134

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) 5/26/2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 X Residence 6 Other (Specify)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3169 Braverton Street, #101, Edgewater, MD 21037 Carol A. Pressey,

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

31. Date filed (Month, Day, Year)

29b. Signature and title of certifler

1 Tes 2 No

27 Manner of Death

2 Accident

4 Homicide

(Check only one)

1 X Natural

3 Suicide

MAY 2 7 2009

32. Registrar's Signature

28a. Date of Injury (Month, Day, Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) IJURI O 1350M **Physician** UBERT /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Harwood Mandrin Chesapeake Hospice House 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, May 24 9. Birthplace (State or Foreign . 193**7 Funeral** Days Hours Months M 2 F Texás 72 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28e-f show 10a. State 10b. County 1 AYes 2 No Director Bowie Maryland Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.
snt: if item 27 ie marked other then "naturel", or Items 23e or yor other treumelic event. It as Marie Exemine Inset bei USA 20715 12100 Long Ridge Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 TNo Baltimore, Maryland 21215-0036 Specify. Black Specify: If Yes, Give 1958-64 Year or Dates: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Exterminating Company Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Fulton Durio Alberta Bernard 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12100 Long Ridge Lane, Bowie, MD 20715 19a. Informant's Name/Relationship (Type, Print)
Geraldine C. Durio/Wife permit, Pages 1 and 2 s Department of Health ar Importent: If item 27 le any injury or other treu once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition May 30, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Olney, Maryland Norbeck Memorial Park <sup>3</sup> 4 □ Donation 5 □ Other (Specify) 2009 21. Signature of Funeral Service Licensee 27 Name and Address of Collins Funeral Home Inc. W00871 500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. Anter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, TROSTATE Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine and Il-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial Box 68760 Physician/Medical the IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ be 1 ☐ Yes 2 ☐No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 🗆 No 2 **H**6 certificate 1 🗌 Yes Division of Vital Hospitel or Attending Physicien: 26. Place of Death (Check only one) MANDAIN 25. Was case referred to medical examiner' HOSPILL Other: 4 Nursing Home 5 Residence 6 Ither (Specify) 2 1 ☐ Yes 2 ☐ No 1 🗀 Inpatient 2 ER/Outpatient 3□ DOA After this funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) HOUSE Certification: 27. Manner of Death 1 Natural 5 Pending М 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeref Director: A 2 Accident investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated To the 29b. Signature and title

Registrar
DHMH 17 Rev 1/2001

State

ame and address of pe

31. Date filed (Month, Day, Year)

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NSE

eted cause of death (Item

Wn 44

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery 01ney Montgomery General Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 13,1915 9. Birthplace (State or Foreign Country) Washington, DC 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1 X M 2 ☐ F **Funeral** Min. Months Days Hours 94 578-01-4722 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f show r than "natural", or items 23a or 28a-f show the Medical Evantimer - ust be notified at 1 Yes 2 □ No Director Maryland Montgomery Burtonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States of America 20866 23a Funeral 14605 Dowling Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 MNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 ☐ Never Married 2 X Married Specify: Caucasian altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 2 3 Widowed 4 Divorced Completed 16b, Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Telecommunications 12 Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) pe and Mental Health and Menta em 27 is marked Effie S. Robey John T. Duvall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1604 Ruxton Road, Edgewater, MD 21037 James B. Duvall - Son permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 

Burial 2 □ Cremation 3 □ Removal from State 05/28/2009 Burtonsville, MD Union Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HInes-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Sen 11800 New Hampshire Ave Silver Spring, MD 20904 Approximate Interval Between Onset and Death 23a. Part 1. Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examir The law requires that the death certificate be executed Due to (or as a consequence of): burial Box 68760, physician the burial Physician/Medical attending p SB IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) P.O. I signed by the aid be detached to ☐Yes 2☐No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform this certificate 1 ☐ Yes 2 ☐ No 2 No Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 2 ☐ Accident 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the ft. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Bev 1/2001

Mospita

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

120054

18/01 Prince philip Drive Ulney, MD 20832

State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician EDWARD** DEFALCO 05 **JAMES** 28 2009 0710 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** WMHS MEMORIAL CAMPUS CUMBERLAND <u>ALLEGANY</u> If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day Y March 2, 9. Birthplace (State or Foreign New York 7. Age (In vrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months 1**∑** M 2 □ F 85 Director 077-18-2183 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 28a-f show ir than "natural", or items 23a or 28a-f showing Wedical Exemple: right be notified at 1 ☐ Yes 2X No Director Grantsville MD Garrett 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21536 89 Root Beachy Rd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1▼]Yes 2□NoWW 2, IfYes, Give Year or Dat≰orea, V Race - American Indian, Black, White, etc. 11 Marital Status 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 🕱 No Specify: 9 White 3 Widowed 4 Divorced Vietnam Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Inc. M. SFC (P) (Ret. U.S. Army 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clara DeVito Joseph DeFalco 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O. Box 362, Grantsville, MD 21536 Sheila K. DeFalco/Wife Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Country Side Crematory June 2, 2009 Davidsville, PA 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service License P.O. Box 275, Grantsville, MD uma Approximate Interval Between Onset and Death 23a. Part 1. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart fillure. List only one cause on each line. Immediate Caus (F al disease or condition resulting in death) **Physician** /Medical Due to (or as a cons quence of): Examiner diam 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No signed by the a P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 3 Probably 4 Unknown 1 ☐ Yes certificate has been s irector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy performe 1 □Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie (m) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) O+VA Ranjithan, M.D., 517 Oldtown Rd., Cumberland, MD 21502 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 02 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #5 per FH G892 6/15/09 TT
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 24, 2009 Year B. May Greta Davis 9:10 A. M 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 8218 Yellow Springs Road Frederick Frederick 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1 □ M 2🎛 F 84 16, 1924 Colorado Aug. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No Maryland Frederick Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21702 USA 8218 Yellow Springs Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2**X**☐ If Yes, Give Year or Dates: 2**X**No 1 ☐ Never Married 2 ☐ Married 1 □Yes 2√XNo Specify: White 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Business Office Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) David John Black Ellie Billingsley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8218 Yellow Springs Road, Frederick, Md 21702 Linda Freeman/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5/30/2009 Blanding Cemetery Blanding, Utah 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home, PA 21. Signature of Funeral Service big 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1621 Opossumtown Pike, Frederick, MD 21702 Approximate Interval Between Onset and Death Immediate Cause (Final HYPOXIA minutes Due to (or as a consequence of): ONGESTIVE HEART PAILURE thing Due to (or as a consequence of)

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

10a, State

Director

Funeral

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Completed

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'w Markel Examinar must be notified at

is marked other

permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any Injury or other trau

72 hours after

Baltimore, Maryland 21215-0036

law requires that the death certificate be executed attending physician and for use as the burial-transit signed by the a peen page 2 s has Physician: The this certificate director, funeral

After t

Director: A

or Attending

death.

after

To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b

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Completed

Be

Medical Certification: To

Box 68760,

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Records,

Division of Vital

disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐Yes 2 ☐No 9 Unknown

Natural

2 Accident

(Check only

₃ 3 ☐ Suicide

CIRRITUSIS Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown

3 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypothyroidism Diabetes Mellitus Arrythmie

perlipidemic

24a. Was an autonsy performed? 1 ☐ Yes 2 ☑ No

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

(OPD) 25. Was case referred to medical 26. Place of Death (Check onl one) examiner? 1 ☐ Yes 2 No Other: 4 \sum Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of D ath 28a. Date of Injury (Month, Day, Year)

28c. Injury at Work?

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Residence 6 Other (Specify)

6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier A Human Ma vaas

5 Pending

investigation

29c. License number 04686

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PREDERICK M DRIVE NAAZ. A-HUSSAIN. M.D 195 31. Date filed (Month, Day, Year)

State Registrar

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup> 2009 7:45AM **Physician** Ruth V. Doss June /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 1511 Ridge Road Whiteford Harford 8. Date of Birth (Month, Day, July 7, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min West Virginia 1 □ M 2 □ yF 87 1921 218-40-5798 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hyglene. It is marked other than "natural", or items 23a or 28a-f show other traumatic event, the walcal Evanting rust by rotified at 1 ☐ Yes 2 X No Director MD Harford Whiteford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21160 USA 1509 Ridge Road Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ∐Yes 2 🔀 No Specify: Specify: White ģ 3 □ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nora May Kennison William Colbert Cutlip ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other trau 1511 Ridge Road, Whiteford, MD Naomi Anders/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Mem.Gardens 6/9/2009 Bel Air, Maryland 22. Name and Address of Facility 21. Signature of Funeral Harkins F.H.Inc., 600 Main St. Delta, PA 17314 Kober 23a. Part 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Est only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 5 days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of) Examiner sician and burial-transit law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe • Hospital or Attending Physician: The 24 hours after death.
• Funeral Director: After this certificate h 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) funeral director, 25. Was case referre medical examiner? Be Other: 4 \( \text{Nursing Home} \) 5 Daughter Specify 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Cutpatient 3 ☐ DCA Certification: To 27. Manny of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 V atural 5 Pending investigation 1 ☐ Yes 2 🖬 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar

DK

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30. Name and address of per

31. Date filed (Month, Day,

Bernadette Mar

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			For State Registrar		State of	Marylan		artment e rtificate			Mental Hy	ygier Reg. N	~ ~ U U )	9	862
	Physic	an	1. Decedent's Name	e (First, Middle, La	st)						2. Date of D		ay Year		Time of Death
	/Medi			ROBERT	ANDRE	V FRE	MMING				May	24,	2009		3:00 A M
,	Examir	er	4a. Facility Name (I	f not institution, giv	e street and num	iber)		4b. City, To	4b. City, Town, or Location of Death		1	4	c. County of De	ath	
			5. Social Security N	ederick M		Hospit		Fred	erick	C Jnder 24 Hrs.	9 Date of B		Frederi		(State or Foreign
Н	Funeral Director		468-30-4		<b>™</b> 2□ F	85	Yrs.			ours Min.	8. Date of B (Month, D 04/26/	ay, Yea	(r) (3. 6)	ountry)	(State of Foreign
			Usual Residence of			0J					04/20/	172	1 1	Owa	
	rylan ihow	_	10a. State	10b. County		10c. Cit	ty, Town or Lo	cation							nside City Limits
	e Ma	cto	Maryland	Frederic	ck	1	Freder	Lck						1	Yes 2 No
	or 28	Dire	10e. Street and Nur					10f. Zip Co					Citizen of What C	-	
	eath with the Marylan ns 23a or 28a-f show must be notified at	ral	990 Wate	rford St					L <b>7</b> 02				ited Sta		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and hental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examir or must be rectified at once.	Completed by Funeral Director	11. Marital Status 1	ied 2 Married	12. Was Dece Armed For 1 XYes If Yes, Giv Year or Da	ces? 194 2 No 196	41-	Vas Deceden f Yes, specify I □Yes 2 ☑	Cuban, M	nic Origin? (S lexican, Puert pecify:	pecify Yes or N o Rican, etc.)	0-	14. Race - An Black, Wh Specify: To		
5-(	72 h	etec	(Spec	15. Decedent's Ed	ducation ade completed)		16a. Deced	dent's Usual C	occupation	ı g most of wor	kina	16b.	Kind of Busines	s/industry	y
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2	iled w Hygie ther t	ပ္ပ	17. Father's Name (	(First Middle Last	<u> </u>	<u> </u>	Buag	get Ana		Mothor's Non	ne (First, Middle	e Maide	N. I. H	L •	
ano	d be f ental ced or	Be C									hel Dav		,		
2	sho for mark mark	ဍ	Robert S  19a. Informant's Na				19h Mailin	a Address (S		<del></del>			or Town, State	Zin Cod	(a)
N	od 2 state all the all			rthur Fre		Son)		-				-	y, MD. 2		
Baltimore, Maryland	s 1 ar		20a. Method of Disp				Place of Dispo cemetery, cren			May		<del></del>	Location - City of		
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===	mit. Joartm		21. Signature of Fu			1100		. Name and A			eVol Fu	<u> </u>		, V 1	.rginia
m	Depa Depa Impo any L		10 East Deer Park Drive Gaithe											, MD	. 20877
			23a. Part 1. Enter the	e di ase, or com	plications that ca	used the death	h. Do not ent	er the mode o	f dying, su	uch as cardiad	or respiratory	arrest,		App	roximate rval Between
india,	Physician		Immediate C use (	Final	Chie cause on es		Ke							Ons	et and Death
3	/Medical		resulting in death)		a Due to (c	or as a consequ									
	Examiner		Sequentially list con	nditions	b										
7	ad sit	ine	if any, leading to import cause. Enter Under	mediate rlying	Due to (d	or as a consequ	uence of):								
P	ecute and -trans	Examiner	Sequentially list cor if any, leading to imi cause. Enter Under Cause (Disease or that initiated events resulting in death) L	injury	C. Due to /s									10	
60,	be e) ician burial		, , , , , , , , , , , , , , , , , , ,		Due to (c	or as a consequ	uence or):								
68760,	ficate be executed physician and s the burial-transit	edical		•	d									+	
O. Box (	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent in the past 12: 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?		rth 2 🗍 Feta ant at time of d	Ideath 3□	Ectopic preg Other (speci					23d. Date of d Month	elivery Day	Year
σ.	that hed by deta		Part II. Other signifi	icant conditions of	ontributing to dea	ath but not resu	ulting in the ur	derlying caus	e given in	Part I.	23e. Did	tobacco	use contribute	to the ca	use of death?
of Vital Records,	uires n sigr ld be	d by	0	ld a	ge						1 0	Yes	2 No 3	Probably	4 Unknown
Ş	w requir s been s should I	Completed		le mes	ntia						24a. Was	s an	24h Were :	autonsv f	indings available
Re	: The law cate has page 2 (	Ę.		000	, , ,						auto	opsy ormed?	prior to	complet	tion of cause of
tal	iclan: Th certificate ector, pag		25. Was case refern	ed to medical					26	Place of Dog	1 ☐ Yes		No   1 LJYe	s 2 🗆	No
<u> </u>	ysician: iis certific director,	o Be	examiner? 1 ☐ Yes 2 ☐	/	Hospital:	patient 2 🗆	ER/Outpatien	t 3 T DOA	Other:				6 ☐ Other (Sp	ocifu)	
0	ding Ph h. After th funeral	Certification: To	27. Manner of Death		28a. Date o		28b. Time of Injury		Injury at Work?		28d. Describe			,cony)	
Ö	ath. ath. pr: Af	atio	1 ☑Natural 2 ☐ Accident	5 Pending investigation	1	i, Day, rear)	mjury	м	1 □Yes	2  No					
Division	al or Attendir s after death. I Director: Ai	tific	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place (	of Injury - At ho g, etc. (Specifi	ome, farm, stre	et, factory, of	fice		28f. Location . City or To	(Street	and Number or I	Pural Rou	ute Number,
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	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune.	Medical	29a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exam	ysician: To the I niner: On the ba and mann	sis of examina	wledge, death tion and/or inv	occurred at estigation, in	the time, d my opinio	ate and place n, death occu	e, and due to the rred at the time	e cause , date a	(s) and manner and place, and di	as stated ue to the	I. cause(s)
	Vithi Vot Com	Ž	29b. Signature and t	1				29c. L	cense nur	nber		29d. E	Date signed (Moi	nth, Day,	Year)
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			30. Name and addre					,							-
			Elena Ia					Street	Fre	derick	, MD. 2	170	1		
	Sta Registra		31. Date filed (Monta	h; Đay, Year) NY 2 7 20	09 22 Re	gistrar's Signa	. ba	Kel							

DHMH 17 Rev 1/2001

MAY 27 2009

State of Maryland / Department of Health and Mental Hygiene 🤈

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2009 Year **Physician** 1:45 PM May 22, David B. Fell III /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Bethesda

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Oct 9, 1961 Bethesda Montgomery 5817 Madaket Road Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F 214-48-7075 **Director** 47 Virginia Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dieal Examinar must be notified at 1 □Yes 2 XNo Director MD Bethesda Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20816 5817 Madaket Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married If Yes, Give Year or Dates: 1 ☐ Yes 2 📉 No 2 Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Computer Technology Computer Programmer 18. Mother's Name (First, Middle, Maiden Surname) At Pages 1 and 2 snows we street of Health and Mental Hearth ortant: If item 27 is marked oft injury or other traumatic ever 17. Father's Name (First, Middle, Last) Be Joanne Ruth Smith David B. Fell, Jr. ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5817 Madaket Rd. Bethesda, MD 20816 Deborah S. Fell/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any Injury or 05/27/09 W. Arundel Crematory odenton, MD 21. Signature of Funeral Service Licensee Coling Middless Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) a Respiratory Failure /Medical Due to (or as a consequence of) Examiner 3 weeks Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) I or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit in by the funeral director, page 2 should be detached for use as the burial-transit. 15 years Multiple Sclerosis resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ZNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 🛣 No 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) ical Certification: To 1 Inpatient 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D17247 May 26, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carlo Tornatore, M.D. 3800 Reservoir Rd. NW Washington, D.C. 20008

Registrar

State

31. Date filed (Month

21215-0036

Maryland

Baltimore,

P.O. Box 68760,

of Vital Records,

Division

barks

32; Registrar's Signatur

## Please Type or Print in Black Indelible Ink. Ensu

Months

10f. Zip Code

1 □Yes 21□No

Was Decedent of Hispanic Or If Yes, specify Cuban, Mexica

7. Age (In yrs. last birthday)

10c. City, Town or Location

SUITLAND

72

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 L No If Yes, Give Year or Dates:

State of Maryland / Department of Health a Certificate of Death

4b. City, Town, or Location

If Under 1 Year | If Under

20746

Days

CLINTON

Hours

Specify

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ind M	lental Hy	giene Reg. No.	20	109	186	24			
-	2. Date of De MAY 25		9	Year	3. Time of De 12:45P	ath M			
Death 4c. County of Death PRINCE GEORGES									
24 Hrs. 8. Date of Birth Month, Day, Year) 1936 9. Birthplace (State or Foreign MARYLAND									
				1	0d. Inside City				
				What Cour					
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t of work	ing			usiness/In					
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Physician /Medical Examiner 1 - For State Registrar

10a. State

MD

5. Social Security Number

217-32-3728

10e. Street and Number

11. Marital Status

Usual Residence of Decedent

1. Decedent's Name (First, Middle, Last)

4641 LAMAR AVENUE

1 ☐ Never Married 2 ☐ Married

3 Widowed WDivorced

JAMES VINCENT FARMER

4a. Facility Name (If not institution, give street and number)

SOUTHERN MARYLAND HOSPITAL CENTER

6. Sex

PRINCE GEORGES

1**★** M 2□ F

**Funeral** 

Director Director Funeral þ

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ire Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work)	16b. Kind of Business	/Industry							
Elementary/Secondary (0-12) College (1-4or 5+)	TRUCK DRIVER	CONSTRUCT	ION							
15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  17. Father's Name (First, Middle, Last)  JOSEPH VINCENT FARMER	18. Mother's Name NAOMI H	e (First, Middle, Maiden Surname) ICKS FARMER								
19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street and Number or Rur									
MARYANN FARMER	1032 DORSET DRIVE, WAI									
	cemetery, crematory or other place)	20c. Location - City of LAPLATA,								
LYDIA C. THORNTON JOHNSON M	THORNTON FUNERAL H DO583 3439 LIVINGSTON RO	OME, P.A AD, INDIÂN HEAD, M								
23a. Part 1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause the each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a constitution)			Approximate Interval Between Onset and Death							
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  A FENDATORY AILURE  Due to (or as a consequence of):										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of preduction in the past 12 months? 4 □ Pregnant at time of preduction in the past 12 months? 9 □ Unknown	Month									
Part II. Other significant conditions contributing to death but not I		co use contribute to the cause of death?  2 No 3 Probably 4 Unknown								
Sequentially is contained at cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		24a. Was an autopsy performed? 1 \( \triangle Yes \) 2 \( \triangle No \) 1 \( \triangle Yes \)								
25. Was case referred to medical		th (Check only one)	=;•.							
1 Yes 2 No  1 Yes 2 No  27. Manper of Death 1 Natural 5 Pending (Month, Day, Year	28b. Time of 28c. Injury at	ome 5 ☐ Residence 6 ☐ Other (S <sub>i</sub> 28d. Describe how injury occurred	pecify)							
2 Accident	2 Accident 3 Suicide 6 Cold not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (St.									
29a. Certifier (Check only one)  1 Certifying Physician: To the best of my Medical Examiner: On the basis of examand manner stated.	(Check only 2 D Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)									
29b. Signature and title of certifier	29c. License number 5 3 8 8 5		2009							
39. Name and address of person who completed cause of death (		307 CUNTON 1	nd 20735							
31. Date filed (Month, Day, Year)  32. Registrar's Si	gnature B. Jack									

Registrar

State

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MAY BA 2ზზ9 **Physician** 1:15 PM FINNEY Υ. MARY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S MITCHELLVILLE VILLA ROSA NURSING HOME If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, JAN 2 I 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min. Months Hours 1916 1 □ M 2 1 F PENNSYLVIA 93 202-20-0510 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits the Maryland 10a State 10h. County ns 23a or 28a-f show 1 ∀Yes 2 □ No Director MD PRINCE GEORGE'S UPPER MARLBORO 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code death with USA 20774 9106 ARDWICK ARDMORE ROAD Funeral r items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married BLACK Baltimore, Maryland 21215-0036 1 ☐Yes 2 🛣 No Specify: th and Mental Hygiene.
7 is marked other than "natural", or traumatic event, The Medical Event Specify 9 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT TEACHER 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **JACKSON** MARY JANE. JAMES CARFIELD YOUNG 9 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20774 19a. Informant's Name/Relationship (Type. Print) ant of Health a t: If item 27 is y or other trau 9106 ARDWICK ARDMORE ROAD UPPER MARLBORO, MARYLAND JOSEPH S. FINNEY JR./SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any Injury or once. RIVERDALE, MARYLAND RIVERDALE CREMATORY :5/22/2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Atherosclerotic Heart Disease vears disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Chronic Kidney Disease years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dub to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed weeks Severe Anemia physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Dav Year 4 ☐ Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown After this certificate has been signed by funeral director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by Diabetes Mellitus 2½ No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? Pneumonia 24a Was an autopsy performed? 2 ⊠No 1∐Yes 2⊠No 1 ☐Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1∐Yes 2⊠No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ours after death.
neral Director; #
filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Funeral C 29a, Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ₹ p 22, 2009 D20108 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14300 GALLANT FOX LANE SUITE 222 BOWIE MARYLAND 20715 RAKESH ARORA M.D. 31. Date filed (Mo State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygienes Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 13, 2009 10:50 A M May George Emlem Graham /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Silver Spring Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 9. Birthplace (State or Foreign Country) Washington DC 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Year) 1 X M 2 □ F 1928 November7, 80 **Director** |218-24-6871 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show r than "natural", or items 23a or 28a-f show 1X Yes 2 □ No Director Silver Spring MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20906 United States 12503 Feldon Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Black, White, etc. 72 hours after 1 ☐ Never Married 2 X Married If Yes, Give Year or Dates: 1953 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 than "natural", or Specify Specify: White ò 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Postal Mailman 12 should be filed what and Mental Hygiel 7 is marked other the 18. Mother's Name (First, Middle, Maiden Surname) traumatic event, 17. Father's Name (First, Middle, Last) Be Eloise Ragan Douglas George Emlem Graham ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 si Department of Health an Important: If item 27 is 1 any injury or other trau 20906 12503 Feldon Street, Silver Spring, MD Doris Graham, Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Fort Lincoln Crematory 5/28/2009 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simple Tribute 21. Signature of Foneral Service Licensee • 20850 1040 Rockville Pike, Rockville, MD 23a. Part 1. Er er the dissa s, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail re. List only one cause on each line.

Immediate cause (Final disease or c indition resulting in death)

Aspiration Pneumonia Approximate Interval Between Onset and Death Physician /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions Due to (or as a consequence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed burial-transi Old Age attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No I ☐ Pregnant at time of death 5 Other (specify) ed by the a Ö 9 Unknown 9 Unknown σ. signed t d be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown icate has been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 \ No 1 ☐Yes 2 🖾 No 1 ☐ Yes Physiclan; funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 2X ER/Outpatient 3 □ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 5 ☐ Pending investigation 1 X Natural 24 hours after death. Prince Director: A selety filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number May 13, 2009 H54837 VA-ORL 30. Name and address of person the completed cause of death (Item 23a) (Type, Print) Khanh Quoc 1500 Forest Glen Road, Silver Spring, MD Dr. Nguyen Do,

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

MAY 27

2009

3. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) May 22, Day 2009 Year 4:25 A M Physician Gladys Lopez Gonzalez /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Germantown 12802 Sage Terrace Birthplace (State or Foreign Country)
 Chile 8. Date of Birth (Month, Day, Apr 26, If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 💢 F 1944 65 Director 212-33-2146 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it a Medical Examinet must be notified at 1 ☐ Yes 2X No Germantown MD Montgomery Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 12802 Sage Terrace 20874 by Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 □XYes 2 □ No Specify: Yes. Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Chilian Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Residence Domestic Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (unk) (unk) ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sandra S. Galkin/POA/Executrix 8011 Grand Teton Drive Potomac, MD 20854 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 05/23/09 Odenton, MD W. Arundel Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Göing Home Cremation Service P.O. Box 784 MO1251Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Breast Cancer **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physiclan: The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical attending p for use as t IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 💆 No 4 Pregnant at time of death 5 Other (specify) s been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 sl autopsy performed? yes 2 2 No 1 ☐ Yes 2 No 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ġ Certification: To this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? After 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

State Registrar

29b. Signature and title of certifier

10

Cheryl A. A. 31. Date filed (Month Day) 2730 University Blvd. W. Suite 400 Wheaton, MD 20902 M D 32. Régistrar Aylesworth, Pay Year) AY 27 2009

29c. License number

D54378

29d. Date signed (Month, Day, Year)

May 22, 2009

		State of Mary		rtment of H tificate of D		, ,	liene 2009	18628
		Registrar  1. Decedent's Name (First, Middle, Last)				2. Date of Deat		3. Time of Death
Physicia /Medic		Alice Mae Gasiorowski				May	23 2009	
Examin	er	4a. Facility Name (If not institution, give street and number) Ellicott City Health and Reha	ab	4b. City, Town, or E.	Location of Death Llicott C	ity	4c. County of Deat	_
Funeral		5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	year) 9. Birl	thplace (State or Foreign
Director		579-30-6623 1□ M 3 T 83  Usual Residence of Decedent	3 Yrs.		1.00.0	April 1	3, 1926 M	aryland
aryland show	J.		c. City, Town or Loc		ridge			10d. Inside City Limits 1 □Yes 2 ☑ No
ith the Maryland or 28a-f show	Director	10e. Street and Number		10f. Zip Code		1	0g. Citizen of What Co	puntry?
s 23a c	eral [	6412 Southampton Court		Non Donaton Addition	21075	acifu Van or No	U.S.A	
filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Modical Examinating the million at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever Armed Forces?  1 □ Yes 2 □ No lif Yes, Give Year or Dates:		Vas Decedent of Hi f Yes, specify Cubal I □Yes 2¶ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	Rican, etc.)	Black, Whit	e, etc.
n 72 ho "natu	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	lent's Usual Occupa kind of work done d OO NOT use retired.	luring most of work	ing	16b. Kind of Business	'Industry
d withi giene. er thar	Somp	Elementary/Secondary (0-12) College (1-4or 5+)		Bookkee			Bookke	eping
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", any Injury or other traumatic event, Ihu Medical Exaging.	To Be (	17. Father's Name (First, Middle, Last)  Everett Austin			18. Mother's Name	e (First, Middle, ie Dale		
and 2 shoralth and 1 strains ar trauma		19a. Informant's Name/Relationship (Type. Print) Jeff Gasiorowski/son					r, City or Town, State, lge, Maryla	
Pages 1 and of He ant: If Item		1 KDBUriai 2 Li Cremation 3 Li Removal from State	_	sition (Name of natory or other place		0/2009	20c. Location - City or	Town, State e, Maryland
permit. P Departme Importan any Injur		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licenses		. Name and Addres			aylor Funer	<u> </u>
8 8 E 8		Joan E will			Glouces	ter St.,	Annapolis	
		23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.  Immediate Cause (Final					rest,	Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)  a. Due to (or as a co	nsequence of):	HEARY	DISE	ASE		YEGVS
Examiner	_	Sequentially list conditions, b. DEME						years
uted 1 Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	nsequence of):					
e execuan and urial-tra	Еха	resulting in death) Last C Due to (or as a co	nsequence of):					
cate by	edical	d						
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown  23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	/		23d. Date of de Month	elivery Day Year
s that igned by	by Ph	Part II. Other significant conditions contributing to death but no	ot resulting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use contribute t	
require een siç rould b						1 🗆 Y		robably 4 Unknown
The law ate has b page 2 sh	Completed					24a. Was autop perfor	sy prior to med2 death?	utopsy findings available completion of cause of s 2 \( \sum No
certific rector,	Be	25. Was case referred to medical examiner?  Hospital: Hospital:		Othe	26. Place of Deat			
g Physer this eral di	n: To	27. Manner of Death 28a. Date of Injury	2 ER/Outpatier	IT 3 L DOA	Nursing He		lence 6 Other (Sp low injury occurred	ecify)
ending eath. or: Aft the fun	atio	Natural 5 Pending (Month, Day, Ye	ear) Injury		Yes 2 □ No			
tal or Att s after de al Direct ed in by t	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc. (S	At home, farm, str Specify)	eet, factory, office		28f. Location (S City or Tow	Street and Number or F vn, State)	Rural Route Number,
e Hospit 124 hour e Funer detely fill	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of m 2 Medical Examiner: On the basis of examiner and manner stated.	amination and/or in	h occurred at the tir vestigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and manner date and place, and du	as stated. le to the cause(s)
To thi	ž	29b. Signature and title of certifier		29c. Licens			29d. Date signed (Mor	
Bo,		Description of description of death	(Itom GGa) (Time	DOE	5315	0	MAY 25	11 C00 9
3		30. Name and address of person who completed cause of death	7A 96	SOSAN	UTIAGO	O RD	COLU	110 MBIA MBIA
Sta		30. Name and address of person who completed cause of death  SHAKU:VMARA COP  31. Date filed (Month, Day, Year)  MAY 26 2009  32. Registrar's	Signature					140 5104
Registr	ar	MAT 40 LUUS CERMA	p. 191	W.Co.				

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		1 - State of Maryla State of Maryla Registrar		artment of F rtificate of l			iene <sub>eg. No.</sub> 200	9 1862
Dhusis		Decedent's Name (First, Middle, Last)				Date of Deat     Month	h Day Yea	3. Time of Death
Physic /Med		Louise S. Gongee				May 24,	2009 Yea	7:40P M
Exami	ner	4a. Facility Name (If not institution, give street and number)			Location of Death		4c. County of De	
~!* 		Glen Burnie Health and Rehab  5. Social Security Number   6. Sex   7. Age (In )	yrs. last birthday)	Glen Bur	nie If Under 24 Hrs.	8 Date of Birth	Anne Arı	
Funeral Director		262-04-0297 1□ M 2K) F 75	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 2/12/19	934 Mis	Birthplace (State or Foreign Country) SSOUTI
land ow		Usual Residence of Decedent  10a. State 10b. County 10c.	City, Town or Lo	cation				10d. Inside City Limits
Mary 1-f sh	ģ	Maryland Anne Arundel Ed	lgewater					1 □Yes 2 No
th the	Director	10e. Street and Number		10f. Zip Code		1	0g. Citizen of What	Country?
ath will	la I	2704 Saffron Place		210	)37		U	SA
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Madical Examin units to notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of H fYes, specify Cuba 1 □Yes 2No	Ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, Wi	nerican Indian, nite, etc. White
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ithin 7	age.	Elementary/Secondary (0-12) College (1-4or 5+)	I		during most of work i)		Home	
Hygie Ther ti		17. Father's Name (First, Middle, Last)	Caret	aker	18. Mother's Name			
d be f ental ced o	o Be	Bud Boitnott			Nettie	·	unknown)	
shoul Mund Mund Mund Mund Mund Mund Mund Mund	ဥ	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street			; City or Town, State	e, Zip Code)
and 2 alth a alth a 27 is		Leonard A. Rollman/Stepson	2704	Saffron H	Place, Edg	gewater,	MD. 21037	
of He roth		20a. Method of Disposition 2 Demously from Atala	b. Place of Dispo cemetery, cren	sition (Name of natory or other plac	ee)	Date	20c. Location - City	or Town, State
Pages ment of tant: If it		1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation & ☐ Other (Specify)					Cheltenhar	·
Deparmit Depart Import any in		21. Signature of Funeral Service Lipensee					Kalas Fund Igewater,N	
		23a. ar . Enter the dise se, or complication that caused the d shock, or heart failure. List only one cause on each line.	eath. Do not ent	er the mode of dyin	ng, such as cardiac	or respiratory arr	est,	Approximate Interval Between
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/Medical Examiner								
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The law requires that the death certificate has been signed by the attending I sage 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No  23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F	etal death 3	Ectopic pregnanc Other <i>(sp</i> ec <i>ify)</i>	у		23d. Date of Month	delivery Day Year
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ires that signed to	þ	Part II. Other significant conditions contributing to death but not	resulting in the ur	nderlying cause give	en in Part I.	23e. Did tol		to the cause of death?  Probably 4 ☐ Unknown
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ding Physician: The law h. h. After this certificate has funeral director, page 2	Completed	Deer vern MARINES		2.6		24a. Was a autops perform	sy prior med?∕ death	autopsy findings available to completion of cause of ?
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ysicia is cer direct	To Be	examiner?	2 ☐ ER/Outpatien	nt 3 DOA Othe			ence 6 ☐ Other (S	necify)
Attending Physician: r death. ector: After this certific by the funeral director, i		27. Man r of Death 1 Natural 5 ☐ Pending (Month, Day, Year	28b. Time of				ow injury occurred	
tendii eath. or: A the fu	catic	2 Accident investigation			Yes 2 ☐ No			
i gig e	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide determined building, etc. (Sp	t home, farm, stre ec <i>ify)</i>	eet, factory, office		28f. Location (Si City or Town		Rural Route Number,
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the Hospital hin 24 hours a the Funeral npletely filled	ledical	(Check only one) 2 Medical Examiner: On the basis of examenation and manner stated.	nination and/or in				· · · · · ·	
<b>5</b> with	Σ	29b. Signature and title of certifier	_	29c. Licens	e number		9d. Date signed (Mo	onth, Day, Year)
341		on March Carry	1	D. (m)	11840	36 /	MAY 25,	200/
Many		30. Name and address of person who completed cause of death (	Item 23a) (Type,	3711 F	MEE ST.	ROLT	300.2	1225
St	ate	31. Date filed (Month, Day, Year) 32 Registrar's Si	gnature	10/10	100 71.	LINCI.	FAIR Y	
Regist	rar	MAY 26 2009 Comma	p. 190	area.				

			For State State Registrar		partment of Health and i ertificate of Death		ene 2009	18630
	Physici	an	1. Decedent's Name (First, Middle, Last)			2 Date of Death		3. Time of Death
The second	/Medic Examin	al	DELAWA: 4a. Facility Name (If not institution, give street and		HELMS  4b. City, Town, or Location of Deatl	MAY 18	Day Year 2009	7:50 P <sup>M</sup>
J.	Examin	eı	12100 Sioux Pla		Gaithersbu		MONTGOM	ERY
	Funeral		5. Social Security Number 6. Sex	F 7. Age (In yrs. last birthda	Months   Days   Hours   Min.	(Month, Day, Y	(ear) 9. Birthpla Countr	ace (State or Foreign y)
	Director		212-20-1427 Usual Residence of Decedent	83 Yrs		Apr.12,	1926  Vir	ginia
	arylan show	ř	10a. State 10b. County MD Montgomery	10c. City, Town or			100	d. Inside City Limits 1 □Yes 2 ☑ No
	the Market Marke	Director	10e. Street and Number	G	aithersburg	100	. Citizen of What Countr	
	th with	al Di	12100 Sioux Place		20878	1.09	U.S.A.	, .
	tems term	Funeral	Arme	Decedent Ever in U.S. 1 d Forces?	<ol> <li>Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert</li> </ol>	pecify Yes or No- o Rican, etc.)	14. Race - America Black, White, et	
336	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show 'doal Exantinast be nodified at	by	1 ☐ Never Married 2 ☑ Married 1 ☐ ¥ 3 ☐ Widowed 4 ☐ Divorced Year	es 2 No , Give or Dates: 44-50	1 ☐ Yes 🏋 ☐ No Specify:		Specify: Bl	ack
21215-0036	72 hou natura	Completed	15. Decedent's Education (Specify only highest grade complet	16a. De	cedent's Usual Occupation	kina 16	b. Kind of Business/Indu	ıstry
121	filed within Hygiene. <b>xther than</b> "	jdmo		1e (1-40r 5+)	ive kind of work done during most of wor e. DO NOT use retired) elf-employed	9	Ministe	r
ام 2	al Hygi other /ent, II	Be Co	17. Father's Name (First, Middle, Last)		<u> </u>	ne (First, Middle, Mai		
ylar	should be and Mental s marked o umatic eve	<b>7</b> 0 E	James Helms		Seno	ra Fishe	r	
Baltimore, Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hyglene.  If them 27 is marked other than "natural", or items 23a or 28a-f show it it is marked other than "natural", or other traumatic event, the file float and it is a filed from the traumatic event, the filed from the fi		19a. Informant's Name/Relationship (Type. Print) Dorothy M. Woods	(Daughter)	ailing Address (Street and Number or Ru $11339~{ t Gift}~{ t Rd}$ , $ t G$			
ore,	permit. Pages 1 and 2 Department of Health 8 Important: If Item 27 is any injury or other tra		20a. Method of Disposition 1 □ Removal fr	20b. Place of Dis	sposition (Name of rematory or other place)	Date 20	c. Location - City or Tow	
<u>Ħ</u>	it. Pag rtment rtant: njury c		4 □ Donation 5 □ Other (Specify)	Jerusa	lem Church 5/2		oolesvill	
Ba	Depa Impo any ii		21. Signatur Huneral Service Licente	kind	22. Name and Address of Facility S1			•
			23a: Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause Immediate Cause (Final	nat caused the death. No not on each line.	enter the mode of dying, such as cardiac	or respiratory arrest	t,	Approximate Interval Between Onset and Death
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ď.	w requires that the dispersion signed by the should be detached	by Ph	Part II. Other significant conditions contributing	to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to the	cause of death?
org	require		Acute Cholecy	ctitis		1 ☐ Yes	2 No 3 Proba	bly 4 Unknown
Vital Records,	e law has b ge 2 si	Completed	Cerebrovascul	ar Disease		24a. Was an autopsy performe	prior to com	sy findings available pletion of cause of
		a l	25. Was case referred to medical	ic Renal Ins		1 □Yes 2 □ ath (Check only one)		2 □No
> =	hysic this ce al direc	To B		☐ Inpatient 2 ☐ ER/Outpat	tient 3 DOA Other: 4 Nursing H		ce 6 □ Other (Specify)	
on o	ding F h. After funera	ijo ij	Natural 5 ☐ Pending (/	rate of Injury Month, Day, Year) 28b. Time Injury		28d. Describe how	injury occurred	
Division of	To the Hospital or Attending Physician: To the A hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, to	Certification:	3 Suicide 6 Could not be	lace of Injury - At home, farm, uilding, etc. (Specify)		28f. Location (Stree City or Town, S	et and Number or Rural State)	Route Number,
	pital o				noth accurred at the time, date and place			atod
:	ne Hos n 24 h ne Fun oletely	Medical	(Check only Medical Examiner: On the	ne best of my knowledge, dence basis of examination and/or manner stated.	eath occurred at the time, date and place r investigation, in my opinion, death occu	urred at the time, date	e and place, and due to	the cause(s)
i	To the comp	ž	29b. Signature and title of certifier	/_	29c. License number		I. Date signed (Month, D	-
	50	-	Marlene Vila	signan p	D31362	_	5/19/0	4
	1		30. Name and address of person who completed of Marlene Hayman, M	D. 501 N.	Frederick Ave.	, Gaithe:	rsburg,MD	20877
Ī	Stat Registra		31. Date filed (Month, Day, Year)  MAY 2.7 2009	. Registrar's Signature	to Kad			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician**  $\mathbf{P}^{\mathsf{M}}$ Diana Dorothy Haberman 6:45 May 17, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 15100 Interlachen Drive, #323 Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🗷 F **Director** 83 February 8, 1926 Wisconsin 388-24-2686 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene. is marked other than "natural", or items 23a or 28a-f ehow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2 K No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 U.S.A. Funeral 15100 Interlachen Drive, #323 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □Yes 2 😿 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No altimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: \$ 3 Widowed 4 Divorced Caucasian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retirement Community 4 Dietician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 2 Edna Farrett Thorval Mansen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a : If item 27 is or other train Susan Griffen - Daughter 9204 Stapleford Mall Place, Potomac, Maryland 20854 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any Injury or o once. 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Fort Lincoln Crematory 05/22/2009 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 22. Name and Address of Facility

Simple Tribute and Cremation Center 21. Signature of Fund 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Lung Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause to Issues or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed ng physician and as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) signed by the a d be detached for o 1 ☐ Yes 2 X No 9 Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, <u>8</u> cate has been si , page 2 should b 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 🔼 No 2 | No 1 ☐ Yes 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 🛣 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signatu re and title 29c. License number 29d. Date signed (Month, Day, Year) rtifie MI D35635 May 19, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

Ken Miller, M.D.,

MAY 27

2009

31. Date filed (Month, Day, Tear)

Registrar's Signature

18111 Prince Philip Drive, Suite 327, Olney, Maryland 20832

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 28, 2009 Month Mella Virginia Hitchins 12:004 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death Allegany Frostburg Village Nursing Home Frostburg 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 03, 1924 9. Birthplace (State or Foreign Country) Maryland Days Hours 85 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Frostburg Allegany Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code One Kaylor Circle 21532 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 □Yes 25 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Martha Dawson Frank Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14105 Easy Street SW, Cumberland, Maryland 21502 Melody Fink- Daughter Date May 30, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Cumberland, Maryland Sunset Memorial Park 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A Lonaconing, MD 21539 8 East Main Street 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

Be

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Modical Experimer must be rediffed at once.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):	1 BGZ	Onset and Death
	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):	ASE	
	resulting in death) Last	Due to (or as a consequence of):		
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Sc. If yes, outcome of pregnancy  1	23d. Date of Month	delivery Day Year
	Part II. Other significant conditions cor	ntributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute	)
_			performed?// death	autopsy findings available to completion of cause of ? es 2 □ No
	25. Was case referred to medical examiner?  1 Yes 2 No	Inenital:	ath <i>(Check only one)</i> Home 5 ☐ Residence 6 ☐ Other <i>(S</i>	pecify)
	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)  28b. Time of Solution of	28d. Describe how injury occurred	
	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or City or Town, State)	Rural Route Number,
		sician: To the best of my knowledge, death occurred at the time, date and place ner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.		

29c. License number

29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JUN 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

	-	For State Registrar	State			d / Depa		t of H	lealth a		lental Hy		Z [] [	9	18	633
		Decedent's Name (First, Middle	e, Last)								2. Date of De	ath			3. Time	of Death
Physicia /Medica		Irene G. Has	cins								May	1 9	2	ŎÖ9	2:15	A M
Examine		4a. Facility Name (If not institution	n, give street and	number)			_		Location (				County of			
ž.		North Arundel							Burn:		0.5		nne		ınde1	
Funeral Director		5. Social Security Number 220-05-2720	6. Sex 1 □ M 2X□ F			as <i>t birthday)</i> 92 Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bird Month, Da NOV 2	th Year	16	9. Birth	place (State try) 1 a r	or Foreign
and	}	Usual Residence of Decedent  10a. State 10b. County			10c. City	, Town or Lo	cation							1	0d. Inside	City Limits
Maryl	ē	Maryland Anne	Arunde	1	(	Odent	on								1 □Ye	s 2X No
h the	있	10e. Street and Number					10f. Zip	Code				10g. Cit	izen of W	hat Cour	ntry?	
23a c	<u>e</u> [	2664 Cedar E	lm Dr.					211	13				US.	A		
tems	Funeral	11. Marital Status		Forces?		3. \ 13. \	Nas Deced f Yes, spec	lent of H ify Cuba	ispanic Ori an, Mexicar	igin? (Sp n, Puerto	ecify Yes or No Rican, etc.)	)-		- Americ , White,	can Indian, etc.	
rs aft	by	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	ied l∐ Ye If Yes, Year o	s 2 ∰ No Give rDates:	O		I∐Yes 2	No D	Specify:				Specify:	B18	ack	
2 hou	Completed	15. Decedent	2-1		I	16a. Deced	dent's Usua	d Occup	ation		J	16b. Ki	nd of Bus	siness/In	dustry	-
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t be fi	ñ	17. Father's Name (First, Middle, George Gait)									e (First, Middle, se Nic)			;)		
should nd Me mark	<u> </u>	19a. Informant's Name/Relations				19b. Mailin	ng Address	(Street			al Route Numb			State, Zij	Code)	
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es 1 a of He rothe		Lenwood N. Ha			20b. PI	ace of Dispo emetery, cren	sition (Nan	ne of ther plac	e)	[	Date	20c. Lo	cation - (	City or To	wn, State	
Pagi ment ant: I		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S <sub>i</sub>	3 □ Hemoval fro pecify)	m State	1	. Res	t Ce	met	ery		6-09		ove		Md.	
permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n any injury or other traumatic event, the Medionce.		21. Signature of Funeral Service	4	8 <b>4</b> 4 8 3	7						Mortu apolis	_			01	
		23a. Part 1. Enter me disease, or shock, or heart failure. List	complications tha	at caused t	he death										Approxim Interval B	ate etween
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. ue	spire	consequ		umer	va							Onset and	d Death
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s that	2	Part II. Other significant condition	ns contributing to	death but	not resu	Iting in the ur	nderlying ca	ause giv	en in Part I		23e. Did t	obacco u	ise contri	bute to t	he cause o	f death?
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The law requires that the decate has been signed by the page 2 should be detached	ompiered					4						psy rmęd?	p d	rior to co eath?	ppsy finding	s available cause of
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hysic this ce	2	1 Yes 2 No	Hospital: 1	☐ Inpatien	nt 2□£	ER/Outpatier	it 3□DC	A Oth	er: 4 💆 Nu	ursing Ho	me 5 ☐ Resi	dence	6 □Othe	r (Speci	fy)	
ling P	<u>.</u>	27. Manner of Death  1 Natural 5 ☐ Pending	g ( <i>M</i>	ite of Injury Jonth, Day,	Year)	28b. Time of Injury		8c. Injur Worl	ķ?		28d. Describe	how injur	y occurre	ed		
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tal or Attending Pres after death. al Director: After ited in by the funera		4 ☐ Homicide determ	ined bu	ilding, etc.	(Specify	)	et, lactory	onice			City or To			ii Oi Huii	ar noute ivi	imber,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Colical		g Physician: To Examiner: On the and m		examinat											o(s)
To th withir comp	1	29b. Signature and title of cartifier					290	. Licens	e number			29d. Da	te signed	(Month,	Day, Year)	
Lan		Della	/	MD			$\square \mid \mathcal{D}$	38	958			5/	<i>11/</i>	09		
(CD)		30. Name and address of person	who completed ca	ause of dea	ath (Item	23a) (Type,		1	pris		Cen B	1		1	4	
State		31. Date fled (Month, Day, Year)	L ) ((//s)	. Registrar	r's Signat	ram ure	1191	KWA	4 50	0 6	Kin B	477	ul_	MI	210	6/
Registra		MAY 2				A. A	becks	1								
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09-04276

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 18634 Leo Hill Certificate of Death 1- For State Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day May 29, 2009 0428 hrs Medical Examiner c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Prince George's Cheverly Prince George's Hospital Center if Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** oreign WASHINGTON Days Hours Months DEC. 16 1959 Director 213-76-6948 49 1 XM 2 F Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a, State 10b. County Yes 2 No CHEVERLY PRINCE GEORGE'S items 23a or 28a-f show ust be notified at once. Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 20785 1715 61st AVENUE 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-Funeral 12. Was Decedent Ever in U.S 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces's 1 X Never Married 2 Married 2 X No Yes Yes 2 X No specify: f Yes, Give Year Divorced \$ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) be filed within 72 than, the Medical PRIVATE P.A. and Mental Hygiene. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) iit. Pages 1 and 2 should be file arment of Health and Mental Hy ortant: If item 27 is marked o rry or other traumatic event, the MARY E. KENNEDY Be LEO HILL SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 1715 61st AVENUE CHEVERLY, MARYLAND LEO HILL SR./FATHER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State FT. LINCOLN CEMETERY 6/5/2009 BRENTWOOD, MARYLAND permit. Page Department Other Specify. 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME Signature of Funeral Service License 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Approximate Interval complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Part I. Enter the dis ease, or Between Onset and **Physician** failure. List only one cause on each line. Death **Viedical** Narcotic intoxication Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): requires that the death certificate be executed and tran 23a PII,27,28a-f,perME, g893 7/1/ 09 TT cian/Medical AMENDED physician a XUNPENDED 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Month Year 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown Physi Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö 1 Yes 2 V No 3 Probably 4 Unknown þ ₾. Cocaine use Completed 24b. Were autopsy findings available 24a. Was an Records, prior to completion of cause of autopsy death? performed? this certificate has 1 🗸 Yes ✓ Yes 2 2 No 26.Place of Death (Check only one) 25. Was case referred to medical of Vital Be Other<sub>4</sub> examiner? Nursing Home 5 Residence 6 Hospital: 1 Inpatient 2 FR/Outpatient 3 1 V Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After 27. Manner of Death To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After Certification unk Yes 2X No Division Natural Pending Fd 5/29/09 Fd 4:15 am Director: Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be Suicide unk (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) **Medical** and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie May 30, 2009 O.C.M.E. Olyponte 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Margarita Korell MD. JUN 0 4 2009

DHMH 17 Rev 1/2001 **OCME 2006** 

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM# 20b, c, perFH, G892, 6/24/09, WS

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2009 Month 1 June Joseph D. Hawkins 2259 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Prince Fort Washington Georges Fort Washington Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours Min. 1 X M 2 □ F 577-38-9293 ,DC Oct.17,1929 Wash. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County 1 X Yes 2 □ No PG Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20746 United States 4642 Kendrick Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 【※No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status 1 ☐ Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify. Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Serta Mattress Co. Warehouse Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Fitzhugh Joseph D. Hawkins Naomi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4642 Kendrick Road
Suitland, Md. 20746 19a. Informant's Name/Relationship (Type. Print) Amelia Hawkins/wife 20b. Place of Disposition (Name of Line of Melior Halpla Cem. 20c. Location - City or Town, State **Suitland** 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Com. 6/9/09 4 Donation 5 Dother (Specify) Brentwood, Md. 2. Name and Address of Facility Hodges & Edwards F.H. 21. Ignatury of Funeral Service Licensee 3910 Silver Hill Rd., Suitland, Md. 20746 23a a.1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Impediate Cause (Final disease or condition resulting in death) Prostatic Cancer 30 Days Due to (or as a consequence of) Metastasis to Lung and Bones Sequentially list conditions, if any, leading to in redistricause. Enter Underlying Cause (Disease or injury that initiated events Cancer of Pancreas resulting in death) Last Due to (or as a consequence of): Insulin Dependent Diabetes Mellitus IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 🗖 No 1 ☐ Yes 2 1 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2∏ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural Injury

attending physician and for use as the burial-tran Box 68760, requires that the death certificate be P.0. ed by the a s been signed b should be deta Division of Vital Records, certificate has page 2

**Physician** 

/Medical

Examiner

Examiner Completed Medical

Physician/Medical

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Certification: To

**Physician** 

Examiner

**Funeral** 

Director

28a-f show

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12

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examination and Injury or other traumatic event, the Medical Examination

Baltimore, Maryland 21215-0036

/Medical

To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Sta	te
Registr	ar

DHMH 17 Rev 1/2001

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

6 ☐ Could not be

determined

32. Registrar's Sig

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29d. Date signed (Month, Day, Year) 29c. License number

1 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ☐ Yes 2 ☐ No

Ave. #cloi, Clinton, UD 20735 Branch

State of Maryland / Department of Health and Mental Hygiene 🤈 🗅 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 2:45 P M 19, TOMMIE JUDY MAY 2009 LEE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S HOSPITAL CENTER CHEVERLY PRINCE GEORGE'S 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 □ F 217-44-5634 24,1946 S. Director 63 CAROLINA Usual Residence of Decedent if filed within 72 hours after death with the Maryland II Hygiene.

other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28a-f show the Medical Exat, irrer rives be notified at 1 √2 Yes 2 □ No Director MD. PRINCE GEORGES **BRENTWOOD** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 3715 43rd AVE. 20722 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 ROOFER SELF EMPLOYED permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any illury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UNK. UNK. ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOANN JUDY/WIFE RANDY LA., LAUREL, MD. 20708 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS\_CREMATORY: 5-27-2009 RIVERDALE, MD. 21. Signature of Funeral Service Lipensee 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIO-PULMONARY ARREST /Medical Due to (or as a consequence of) Examiner CHRONIC OBSTRUCTIVE LUNG DISEASE Secure Hally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burst-transit completely filled in by the funeral director, page 2 should be detached for use as the burst-transit CORONARY ARTERY DISEASE Due to (or as a consequence of) Box 68760, Physician/Medical yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ۵ 1 XYes 2 No 3 Probably 4 Unknown HYPERTENSION Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 XNo 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2X ER/Outpatient 3 DOA Certification: To 1 Inpatient 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and 30. Name and ad ress of person who completed cause of death (Item 23a) (Type, Print) R. RAMAN TULI, M.D3503 PERRY ST. #B, MT. RAINIER, MD. 20712 31. Date filed (Month, Day, State Registrar

Physiciar /Medica Examine

Funeral Director

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	If not institution, give s cove Rehab.		าต		4b. City, Town, or Rockvill		eatn			c. County of Death Iontgomery				
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4 □ Donation				runde	el Cremato	ory 05	/22/09		- :	n, MD				
shock, or head immediate Cause disease or condition resulting in death)  Sequentially list or if any, leading to include the cause. Enter this Cause (Disease or Disease)	Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Little U.Jenying Cause (Disease or injury that initiated events  Due to (or as a consequence of):  Due to (or as a consequence of):											veen eath		
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25. Was case refe examiner?	-	lospital:	nt OFFE	Outpoti-	oth		Death (Check onl			ub (O	£.)			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 25, 2009 JOHNSON /Medical MAY 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hyattsville Prince George St THOMAS

5. Social Security Number MOORE If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) Date of Birth (Month, Day, **Funeral** Months Year) Hours **X**□ M 2□ F Days Min. 241 60 5325 Director 70 4/23/1939 North Carolina Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits event, the Medical Examiner must be notified at Director 1 ☐Yes 2 ☐No New Carrollton Prince George Md28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or U.S.A. 20784 3900 73rd Avenue Funeral or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔼 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc. 72 hours after 1 Never Married 2 N Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Yes Give Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Private 10th Parking Lot Attendant is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi Lucile McEachern Johnson Sr. 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Avenue, New Carrollton, Md 20734 Dorothy Johnson, wife 73rd Pages 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of P Important: If ite any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/29/2009|Landover, Maryland Harmony Mem Park 22. Name and Address of Facility HALL BROTHERS FUNERAL HOME 21. Signature of Peneral Service Licenses Colier 621 Florida Avenue, NW, Washington DC 20001 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition ino all avenimen /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed and Due to (or as a consequence of): Box 68760. physician Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) ed by the a o 9 Unknown σ. signed I 23e. Did tobacco use contribute to the cause of death? Records, Completed by 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Physician: The law page 2 autopsy perform espiratono Vital 1 ☐ Yes 2 1 No . Was case referred to medical examiner? funeral director, Be . Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 1 28c. Injury at 28d. Describe how injury occurred Division or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident the within 24 hours atter death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ determined 4 Homicide filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) To the and manner stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State

State Registrar

pate filed (Month, Day, Year)

ANY 27 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vea Physician .54 2009 Jimmie /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner **Baltimore City** The Johns Hopkins Hospital Age (In yrs. last birthday) If Under 1 Year If Under Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 XM 2 □ F Months Days Hours 239-62-9466 65 Feb. 26, 1944 VA Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c City Town or Location 10a. State 10b. County 28a-f show aţ 1 TYYes 2 □ No notified Director MD PG Clinton 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? must be 12308 Chado Court items 23a 20735 United States Funeral and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No 11. Marital Status Black, White, etc. other traumatic event, the Medical Examiner 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 ö 1 Yes 2 XNo Specify: à 3 ☐ Widowed 4 ☐ Divorced Black 'natural", Completed 16b Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) is marked other than Driver Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Chester Joyce Margie Whitlock 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12308 Chado Court Clinton, Md. 20735 permit. Pages 1 and 2 and 2 and 2 moratment of Health ar Important: If item 27 is any injury or other trauonce. Gwendolyn Joyce/wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 6/3/09 1 Burial 2 Cremation 3 Removal from State Riverdale Park Crematory 4 ☐ Donation 5 ☐ Other (Specify) Riverdale, MD 22. Name and Address of Facility Hodges & Edwards F.H. 21. Sig of Funeral Service Licenses 3910 Silver Hill Rd., Suitland, Md. 20746 Approximate Interval Between Onset and Death inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** chaestive disease or condition resulting in death) /Medical Due to ( r )s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. Examiner attending physician and I for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IE EEMALE 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Year in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) ate has been signed by the an page 2 should be detached it 2 □ No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy l or Attending Physician: The law after death. performed? 2/ No Yes 2 🗌 No 1 Yes of Vital 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 3 🗆 DOA 2 ER/Outpatient မ 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Magner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 2 Accident 5 Pending investigation Injury 1 🗌 Yes 2 🗍 No 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

within 24 hours a the Hospital

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie o completed cause of death (Item 23a) (Type, Print)

State

Medical

My 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Registrar

600 North Wolfe St, Baltimore, MD, 21287

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 🖗 🖺 🦳 🤍 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Roger Alfred Lyons May 24, 2009 1:18 p M 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Silver Spring 1119 Fairview Court If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 5, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Months Hours 1 M 2 □ F New York Yrs 081-07-1296 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2X No Silver Spring Montgomery Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20910 USA 1119 Fairview Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status ☐Yes 2☐No Yes, Give 1 Never Married 2 Married White 1 ☐ Yes 2 ☐ No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Foreign Service Officer Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alfred Lyons Florine Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Lyons/Wife 1119 Fairview Court, Silver Spring, MD 20910 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location · City or Town, State 20a. Method of Disposition May 27, 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Metropolitan Crematory Alexandria, Virginia 2009 1 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee MO0837 500 University Blvd., W, Silver Spring MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final years cronary ar disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 Other (specify) 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 XM0 2 □XNo 1 Tyes

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

Director

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**Funeral** 

Director

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Pages 1 and 2 s ment of Health an ant: If item 27 Is: ury or other trau

Department of Important: If any injury or once.

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Saltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

certificate be

Examine physician and s the burial-transit Physician/Medical as the the attending p detached ģ Completed director, Be 2 in by the funeral Certification;

certificate has

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Director:

24 hours

within 2

To the Hospital or Attending Physician:

death.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

26. Place of Death (Check only one)

25. Was case referred to medical examiner? examiner? 27. Manner of Death

tatucia

1 Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 5 Pending investigation

Hospital:

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 sesidence 6 Other (Specify) 3 DOA 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

Vatural

2 Accident

3 🗌 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30, Name and address of person who com Pike, G-100, Rockville, MD 101115KO atricia 31. Date filed (Month; Day, Year)

State Registrar

cai

6 Could not be

determined

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May 22, **Physician** 2009 11:55 A M Betty Wilkoff Levine /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Hebrew Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/01/1918 9. Birthplace (State or Foreign 5. Social Security Number 295–03–5952 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Countr Min. 1 □ M 2 🗓 F Director 91 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the "wolcal Experience is not interest that the restilled at Montgomery Rockville 1 AYes 2 No Director Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20852 United States 6121 Montrose Road Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates: WWII 1 ☐ Yes 21 No Specify 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Isaac Wilkoff Anna Wolf 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7221 Hidden Creek Rd, Bethesda, MD 20817 19a. Informant's Name/Relationship (Type. Print) Jay Freedman/ POA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Wash Hebrew Cem May 26,2009 Washington DC 22. Name and Address of Facility Joseph Gawler's Sons INC 21. Signature of Funeral Service Licensee 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 C Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav Year 5 ☐ Other (specify) 9 Dnknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, 2 funeral director, page 2 should be 1 🗌 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy AL No 2 No 1 ☐ Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) npletely filled in by 4 Homicide 29a. Certifier Medical 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month. Day, Year, 29b. Signature and title of certifier 29c. License number

Registrar

31. Date filed (Month, Day, Year)

121 MON /2055

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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DATEL, MD

O[2]

32 Registrar's Signature

			1 - State of Maryland / Dep	ertificate of L			ene 2009	18642				
	Physicia	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death				
4	/Medic	al	Jesse Frank Minton  4a. Facility Name (If not institution, give street and number)	4h City Town o	Location of Death	May 21	, 2009	2:00P M				
· ·	Examin	er	Holy Cross Hospital		er Spring		4c. County of Death  Montgomery					
	Funeral		Social Security Number     6. Sex     7. Age (In yrs. last birthda)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	O Birth	nplace (State or Foreign intry)				
	Director		229-05-1214 1⊠ × 2□ F 90 Yrs.	World Days	Tiouis Iviii.	NOV. 9,	1918 Vi	rginia				
	land ow It		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or I	_ocation				10d. Inside City Limits				
	Mary a-f sh fied a	tor	Maryland Montgomery Sil	ver Spring	<b>p</b>			1 □Yes X□No				
	th the or 28; e not	Director	10e. Street and Number	10f. Zip Code	<b>_</b>	109	g. Citizen of What Cou	untry?				
	ath wi	rall	3155 Adderly Court		906			s of America				
	ter de items iner m	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No	<ol> <li>Was Decedent of H If Yes, specify Cuba</li> </ol>	ispanic Origin? (Sp an, Mexican, Puerto	ecify Ye's or No- Rican, etc.)	14. Race - Amer Black, White	ican Indian, , etc.				
036	ursaf al", or	by	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give Year or Dates: 1942–46	1 ☐ Yes 2 🙀 No	Specify:		Specify: Ca	ucasian				
21215-0036	filed within 72 hours after death with the Maryland Hygiene. vther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	cedent's Usual Occupa we kind of work done of DO NOT use retired	ation during most of work	ing 1	6b. Kind of Business/I	ndustry				
121	within ene. <b>tha</b> n "	dmo	Elementary/Secondary (U-12) College (1-4or 5+)					Steel				
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Maryland	2 should be and Mental Is marked or raumatic ever	To Be	Jesse Frank Minton		Lucy	McClella	an					
lary	2 shours and No.			19b. Mailing Address (Street and Number or Rural Route Number, City o 15036 Butterchurn Lane, Silver								
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Baltimore,	E L			position (Name of ematory or other plac			Oc. Location - City or T					
턡	permit. Pag Department Important: I any Injury o	1		dge Memor:			Elkridge, di Funeral	Home, Inc.				
ñ	permit. Departi Importi any Inji	1	South					ng, MD 20904				
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximately a specific provided by the cause of the death of the cause of									
	Physician		Immediate Cause (Final disease or condition resulting in death)  Atherosclerotic	ease			Onset and Death					
17	/Medical Examiner		Due to (or as a consequence of):									
		Jer	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	b								
)	ecuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter fundentifing Cause (Disease or injury that initiated events									
60,	be exe	E	resulting in death) Last Due to (or as a consequence of):									
68760,	eath certificate be executed attending physician and for use as the burial-transit	edical	d									
	h certi ending use a		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy				23d. Date of deli	very				
P.O. Box	ed for	Physician/IV	1 \( \text{Yes} \) 2 \( \text{No} \) \( \text{1 Pregnant at time of death} \)	B ☐ Ectopic pregnance ☐ Other (specify)	y 		Month	Day Year				
<u>~</u>	hat the	문	9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting in the	underlying cause giv	en in Part I	23e. Did toba	acco use contribute to	the cause of death?				
Vital Records,	uires t signe	d b	Dementia , Perpheral Vascular Dis	, ,	orrar are i.			obably 4 🗆 Unknown				
ဂ ဂ	s beer shou	lete			24a. Was an	24b. Were au	topsy findings available					
<b>8</b>	The la	Completed				autopsy perform 1 □Yes 2	ed? death?	completion of cause of 2 🔯 No				
/ita	cian: ertifica ector, p	Bec	25. Was case referred to medical examiner?			h (Check only one,		- 7				
of	ding Physician: The h. After this certificate h. funeral director, page		1 ☐ Yes 2 🖾 No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpati 27. Magner of Death 28a. Date of Injury 28b. Time		4 Li Nursing Ho	ome 5 Resider	nce 6 Other (Spec	cify)				
on	th. : After	ţi	27. Manner of Death  1 Anatural 5 Pending (Month, Day, Year)  28b. Time (Month, Day, Year)	/ Worl	yat k? Yes 2□No	200. Describe flow	vinjury occurred					
Division of	· Atter	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)			28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,				
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	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendir completely filled in by the funeral director, page 2 should be detached for use	Medical	29a. Certifier (Check only one)  1									
	ro the vithin roundle	Med	29b. Signature and title of pertifier	29c. Licens	e number	29	d. Date signed (Monti	n, Day, Year)				
3	12		Man dal 20	HO	064588		5/22/09					
			30. Name and address of person who completed cause of death (Item 23a) (Type		<u> </u>							
			Ashish Kishore Tolia, DO 1500 Fore		oad, Silv	er Sprin	g, MD 2091	.0				
	Stat Registra		MAY 27 2009 Reput A. A.	ake								

			State of Maryland / D  State of Maryland / D  Registrar	-	rtment of H tificate of I			iene 0	09	18643	
	Physicia		1. Decedent's Name (First, Middle, Last)  Virginia Lee Miller				2. Date of Dear May 23,	<sup>th</sup> 2009	Year	3. Time of Death 4:30P • M	
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  Manor Care		4b. City, Town, or	Location of Death		4c. County of Death  Montgomery			
	Funeral Director		5. Social Security Number 548-34-1027 6. Sex 1 □ M 2 ☒ F 84		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day June27,	1924	9. Birth	place (State or Foreign Intry)	
71-	D		Usual Residence of Decedent  10a. State 10b. County 10c. City, Tow							10d. Inside City Limits	
the Man 28a-f sh notified	the Mar 28a-f sh notified	irector	Maryland Montgomery Chevy  10e. Street and Number		1	10g. Citizen of					
	leath with	Funeral Director	3809 Underwood Street  11. Marital Status 12. Was Decedent Ever in U.S.	13. V	10f. Zip Code 20815 Was Decedent of H f Yes, specify Cuba		pecify Yes or No-		ce - Ameri	ican Indian,	
200	urs after o al", or iter :xaminer	by Fur	Armed Forces?  1 Never Married  3 Widowed 4 Divorced  Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		fYes, specify Cuba I□Yes 2X No	Specify:	o Hican, etc.)		<sub>fy:</sub> White	•	
5-6-1	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural"; or items 23a or 28a-f show or other traumatic event, the M-dical Examiner must be notified at	Completed	(Specify only highest grade completed)	ation during most of wor. f)	king		6b. Kind of Business/Industry				
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yla	should be nd Mental marked matic ev	To Be	Edmond Willson Roberts  Marie Gannon  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Bural Boute Number, City or Town, State								
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	tmer tant tant		1 □ Burial 2 Incremation 3 □ Hemoval from State 4 □ Donation 5 □ Other (Specify)  Metrop	ooli	tan Crema	etory $5/2$				, Virginia	
ם מ	permit Depar Impor any ir		21. Signature of Funeral Service Licensee				-		Mary	yland 20705	
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  Aspiration I			ng, such as cardiad	or respiratory ar	rest,		Approximate Interval Between Onset and Death	
1	/Medical Examiner		resulting in death)  Due to (or as a consequence of):  Left Lower Extremity - Deep Vein Thromboism								
)	cuted nd ransit	Examiner	that initiated events	Congestive Heart Failure							
0/00,	te be exe ysician ar ne burial-t	dical Ex	resulting in death) Last  Due to (or as a consequence  Dysphagia	, of):							
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	t the deat by the attr ached for	Physician/Me	in the past 12 months?  1 ☐ Yes 2 🗓 No 9 ☐ Unknown		Other (specify)	,			fonth	Day Year	
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on or	iing Phys  After this funeral di	ion: To	27. Manner of Death 1 ☐ Inpatient 2 ☐ EP/O  27. Manner of Death 1 ☐ Inpatient 2 ☐ EP/O  28a. Date of Injury (Month, Day Year)  28b.	how injury occi	3 □Other (Specify) y occurred						
JIVISION OF	or Attendatiter death Director: in by the	Certification:	2 Accident investigation   M   1   Yes 2   No   3   Suicide   6   Could not be determined   28e. Place of injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Ro City or Town, State)								
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Ce	29a. Certifier (Check only one) (Check	ge, deat and/or in	th occurred at the to	ime, date and plac opinion, death occ	e, and due to the urred at the time,	cause(s) and date and place	manner as e, and due	s stated. e to the cause(s)	
	1	Mec	29b. Signature and title of certifier	<u>-</u>	29c. Licen:	se number 274		29d. Date sign	ned (Mont. 25, 2	th, Day, Year) 2009	
	φ		30. Name and a dress of person who completed cause of death (Item 23a) Kirti Vohra, M.D. 7710 Bradley Bly	) (Type,	Print)		nd 20817				
	Sta Regista	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	- 10 -	N.S	, -10 m y mo.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Mav 21, 200**9**ar 11:20A.M W. Rosalie McDonough /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery General Hospital Olnev Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 213-28-0341 8. Date of Birth (Month, Day, Year) June14,1931 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Min 1 □ M 2**X**□ F Mary Land Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits f show 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, I'm Mes Gal Examinat must be notified at 1 ☐ Yes 2 No Silver Spring Mərylənd Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 13104 Marigold Lane 20906 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2X☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary (Secondary (0-12) College (1-4or 5+) Administrative Assistant Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rosa Bruschwein Wagenfuehrer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carl M. Wagenfuehrer -Nephew 10110 Treetop Lane Lanham, Maryland 20706 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or o once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Zion Cemetery 5/27/2009 Freeland, Maryland 21. Signature of Funeral Service Livensee Bonala V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to ( a consequence of) sician and burial-transit Exami resulting in death) Last Due to (or as a consequence of) physician at the burial P.O. Box 68760, Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) cate has been signed by the cage 2 should be detached to 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Hemo chro wator 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1 ☐ Yes 2 ☑ No 1 □Yes 2 **N**o director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred al or Attending F s after death. I Director: After d in by the funera Division 1 🖾 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 24 hours a Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the Hosp within 24 hor To the Fune completely fi Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Registra

29b. Signature and title of certifier

12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Aruna Kumari Paspula, M.D. 18101 Prince Philip Drive Olney, Maryland 20832

29c. License number

29d. Date signed (Month, Day, Year)

May 22, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) John Robert Mansfield 2. Date of Death 3. Time of Death (AKA) Robert John Mansfield **Physician** 11:30 A M 2009 4c County of Death  $\gamma \gamma_{11}$ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner VA Maryland Health Care Suster Perry Point If Under 1 Year | drUnder 24 Hrs. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth Month, Day March 2 **Funeral** 5-Social Security Northber 564-28-5962 Year 1926 California Days Hours 9 Months March Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at North Potomac Maryland Montgomery 1XYes 2 No **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States of America 15181 Winesap Drive 20878 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give 1944-1946 Year or Dates: 1944-1946 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired)

Truck Driver Elementary/gecondary (0-12) College (1-4or 5+) Shipping 18. Mother's Name (First, Middle, Maiden Surname) Frieda Novelman 17. Father's Name (First, Middle, Last) Raymond Hayes Mansfield Baltimore, Maryland Be 19a. Informant's Name/Relationship (Type. Print) John Mans (ield, Jr. (son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15181 Winesap Drive, North Potomac, Maryland 20878 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of H
Important If iter
any injury or oth 1 X Burial 2 □ Cremation 3 □ Removal from State Logandale Cemetery June1, 2009 Logandale, Nevada 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Zellman Funeral Home, P.A. 21078 |123 SouthWashingtonSt. Havre de Grace, Maryland Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Due to (or as a consequence of): Physician Acute Unklower disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical the SS. IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director. 27. Manner of Death

Natural

Accident 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and little of certifie D46723 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) . VA maryland Health Care System Perruf State Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	otato or marytaris	Cer	tificate of l	Death		Reg. No	2009	1891	10
	Physicia	an	1. Decedent's Name (First, Middle, Last)	Makillan				2. Date of D	eath Da	ay Year	3. Time of Dea	
	/Medic	al	Alice Caroline	McMillan		4b. City, Town, or	Leastion of Day	June	1	2009 c. County of Dea	7:15 PM	<u>1</u> <sup>™</sup>
	Examin	er		ome		Lona	coning			Allegan	У	
Ī	Funeral Director		213-12-2214	7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours Mi		Birth Day, Year 28	1920 Ma	hplace (State or Fo unity) ryland	oreign
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Loc	cation					10d. Inside City L	imits.
	Mary a-f sho fled a	tor	MD. Allegany	7	Barto	n					MXYes 2[	] No
	n with the	al Director	10e. Street and Number 18325 Moscow St	-		10f. Zip Code 2152	21			itizen of What Co Led Stat		
5-0036	filed within 72 hours after death with the Maryland Hygiene. vither than "natural", or items 23a or 23a-f show sith, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S Armed Forces? 1. □ Yes 2 □ No WW If Yes, Give Year or Dates:	2 13. 1	Was Decedent of H f Yes, specify Cuba I ☐ Yes 2010	ispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or t erto Rican, etc.)	No-	14. Race - Ame Black, Whit Specify: W		
1215-0	vithin 72 horner. han "natur e Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give life. L	lent's Usual Occup kind of work done o DO NOT use retired SSISTANT	ation during most of w f)	vorking	Ĭ	Kind of Business	•	
and 2	id be filed v ental Hygie ked other t c event, th	To Be Co	12 17. Father's Name (First, Middle, Last) Robert Lancaste	er		_		lame (First, Midd		•		
Maryland	ss 1 and 2 should be in the strength and Mental item 27 is marked or other traumatic ever	Ě	19a. Informant's Name/Relationship (Type Gayle Griffith/ day		1	ug Address (Street US Rt. 2				or Town, State, 15522	Zip Code)	
Baltimore,	permit. Pages 1 a Department of Her Important: if item any injury or othe		20a. Method of Disposition  1 ★Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	CE CE	emetery, crer chart (	sition (Name of matory or other plac Cemetery	20	Date 5/06/ 009	Ecl	Location - City or khart Ma		
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1	w requires that the dibeen signed by the should be detached	by	Part II. Other significant conditions con	tributing to death but not resu	Iting in the u	nderlying cause giv	en in Part I.				o the cause of dea	
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Division or	ing After une		27. Manner of Death  1 Matural 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	M 1	ry at ¹ rk? ∣Yes 2 ☐ No			jury occurred		
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	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in by	Medical	29a. Certifier 1 2 Certifying Phys (Check only one) 2 Medical Examli	siclan: To the best of my kno- ner: On the basis of examinal and manner stated.	wledge, deat tion and/or in	nvestigation, in my	opinion, death o	ace, and due to to courred at the tire	ne, date a	and place, and d	ie to the cause(s)	
	To t To t	Σ	29b. Signature and title of certifier			29c. Licens				Date signed (Moi		
			20. Name and address of pareon who co	moleted cause of death (Item	23a) (Tyne	Print)				NE OT	0001	
	IVA	3	Dr. Harjit Sidhu,	925 Bishop W	lalsh i	Rd., Cumb	erland,	Md. 2	1502			
	Sta Regist		31. Date filed (Month 12 200	32. Fegistrar's Signa	ture A. A	anker						

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ב ב	permit. Pages 1 and 2 should be ined within 72 hours after death with the Marylan Department of Health and Menhatl Hygiene. Important: If liem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signatur uneral Service	Lionis	_ &.	R.T.	Foar	d and	Jone	s, Inc	DE 191	711	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 18 200 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death HNNAPOLI rundel 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number Year) 947 Days Hours Min 1₩ 2□ F June Maryland 219-78-7936 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Yas 2 No Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21403 112 Eastern Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ∐Yes 2 ∐Wio Specify. Specify: Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) N/AN/A 5th 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Virginia Davis Earl Murray 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21403 Annapolis, Md. Jean B. Herndon(Sister) Chester Ave 20c. Location - City or Town, State Date 20b Place of Disposition (Name of cemetery, 2 rematory or other place) 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 5-23-09 Annapolis, Md. Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 22WMme and and sage Facility Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 23a. Part 1. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) Tyes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. heineris 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 14 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner?
Yes 2 □ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 1-Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide

/Medical Examiner

Important: If it any Injury or c once.

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

ral", or items 23a or 28a-f show Examiner must be notified at

event, the Medical

7 is marked other than traumatic event, the W

Director

Funeral

Completed by

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

3altimore, Maryland 21215-0036

Box 68760,

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of Vital Records,

Division

Physician The law requires that the death certificate be executed

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physician the buria signed by the a d be detached f peen has certificate

Physician/Medical ş Completed Be Certification: To

Examiner

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Medical

State Registrar DNES

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

registrar's Signature

4 Homicide

(Check only one)

29a. Certifier

determined

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** Robert Lee Miller 11:20 A.M 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Williamsport 15810 Clear Spring Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Davs Hours Months 1 ☑ M 2 ☐ F 213-40-4348 11, 1942 67 Maryland Director April Usual Residence of Decedent Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County show ns 23a or 28a-f shor 1 √ Yes 2 No Director Washington Hagerstown Maryland the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 819 South Potomac Street 21740 U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Department of Health and Mental Hygiene.
Important: If item Z7 is marked other than "natural", or items with Injury or other traumatic event, the Medical Examination once. 14. Race - American Indian, Black White etc. Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: <u>م</u> White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Trucking 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ellis Miller Arlene Spessard ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 819 S. Potomac St. Hagerstown, Maryland 21740 Eunice Miller 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Ø Cremation 3 ☐ Removal from State Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 2009 22. Name and Address of Facility 21. Signature of Funeral Service Licensee J.L. Davis Funeral Home MO1414 12525 Bradbury Ave. Smithsburg, Maryland 21783 lex Approximate Interval Between Onset and Death 33. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Dhodge disease or condition resulting in death) 10c /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical the attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No 1 ☐ Yes 2 Z No 1 ☐ Yes After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 2 2/100 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 6 Qther (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 2 Accident 5 Pending investigation ours after death.

neral Director: A 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar

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DIL

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) 32. Registrar's Signature JUN 1 0

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

lagerstown, MD 21746

**Physician** /Medical Examiner

and burial-trar ase for has page 2 : certificate filled in by the funeral after death

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Division of Vital Records, P.O. Box 68760,

	21. Signature of Funeral Service License	e	22. Name and A	ddress of Facility	12525	Bradbury	Ave.				
	toller las 1	Davis M01414	J.L. Day	vis Funeral	Home Smith	sbura Md.	21783				
ner	23a. Part T. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury	cations that caused the death. Do not be cause on each line.  Conger to Cong	t enter the mode of	dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death				
Completed by Physician/Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of)	:								
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	Chronic rev	ral pailure,	Pueum	miq	24a. Was an autopsy performed? 1 □ Yes 2 No	prior to com death?	sy findings available pletion of cause of				
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5	20h Cignotetes and title of a setting		80-11		20-1 B	t !   (1.4					

29d. Date signed (Month, Day, Year)

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State Registrar

within 24 hours a To the Funeral L

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

rood

\$2. Registrar's Signature

580 Northern Ave

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, peen certificate this After t

attending physician for use as the burial page 2 should Hospital or Attending 24 hours after death e Funeral Director: in by the within 2

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

marked other than

permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 Is marked other any injury or other traumatic event, I

**Physician** 

/Medical

Examiner

death with the Maryland

filed within 72 hours after Hygiene.

Baltimore, Maryland 21215-0036

DAVID GARTEL State Registrar

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

6 ☐ Could not be

North Street 304-306 22. Registrar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0047711

Suite #3 ELHTON

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

■ Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		For State	State	of Maryla	-	artment of ertificate of		Mental Hy	•	2000	18652
		Registrar				runcate or	Deam	T	Reg. N	0.4000	10004
Physicia	ın	1. Decedent's Name (First, Midda Mildred V. Ocke						2. Date of De Month	Di	ay Year	3. Time of Death
/Medica	al					41. 01. 7		May	20		
Examine	er	4a. Facility Name (If not institution					or Location of Dea	ith		c. County of Deatl	
		Anne Arundel M				Annap		e O Data of Di		nne Arun	
Funeral Director		5. Social Security Number 214-09-3617	6. Sex 1 ☐ M 2 X F	7. Age (III)	rs. last birthday Yrs.	Months Days			ay, <sub>Year</sub> 1918	Mary	hplace (State or Foreign untry) land
p ,		Usual Residence of Decedent		10-	Oit. Tour	A!					10d Incide City Limits
shov	_	10a. State 10b. County		100.	St. Le						10d. Inside City Limits 1 ☐ Yes 2 🛣 No
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or 2	Ë	10e. Street and Number				10f. Zip Code				itizen of What Co	
ath w	ra	4510 Kings Road				2068				ed State	
er de	Funeral	11. Marital Status	12. Was Dec Armed F	orces?	1 U.S.   13	Was Decedent of If Yes, specify Cul	Hispanic Origin? ( ban, Mexican, Pue	Specify Yes or Norto Rican, etc.)	0-	<ol> <li>Race - Ame Black, White</li> </ol>	
or i	by F	1 ☐ Never Married 2 ☐ Mai 3 ☑ Widowed 4 ☐ Divorce	If Yes, G	2 <b>X</b> No ive No		1 □Yes 2 🗓 No	Specify:			Specify: T.	71. 4 4 4
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withi ene. thar	E I	Elementary/Secondary (0-12)	College (	1-4or 5+)	1	maker	/			Home	
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d be ental ked c	To Be	Leo Henson					Ina May	Poffenb	urge	er	
shoul nd M mar	F	19a. Informant's Name/Relation	ship (Type, Print)	<u>-</u>	19b. Mai	ing Address (Stree	et and Number or F	Rural Route Numl	ber, City	or Town, State, 2	Zip Code)
nd 2 :		Marilyn L. Bass		hter	1	Harbor P			-		
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exeminer must be multiped at once.	ŀ	4 ☐ Donation 5 ☐ Other (S		1		Pen Cemer 22. Name and Addi					Maryland
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To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifics completely filled in by the funeral director, for the funeral director.	edical	(Check only 2 Medica one)	Examiner: On the and mar	basis of exam nner stated.	nination and/or i	nvestigation, in my	opinion, death oc	curred at the time	, date a	nd place, and due	to the cause(s)
To the To the Company of the Company	Ž	29b. Signature and title of cartific	7.			l l	nse number			ate signed (Mont	
N. V	)	De Chil	1 N	12		_ D 3	8958		5/	21/09	
XX		30. Name and address of a rsor	who completed cau	se of death (	Item 23a) (Type	, Print)	2 (2)	-			
1000		Datreet Jun	16 South	4 208	Crain	Hickory	8958 4 Sw	Olin Bu	m	1 MD2	1061
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Registra	ır	MAY 27	3 2009	nova	B. A	rave					

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			For State Registrar	State of Maryland	•	rtificate of l		-	gierie Reg. No.	009	186	553
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	D <i>a</i> y	Year	3. Time of	
	/Medi		Mariann M. O'Lear						21, 20		7:00	Рм
	Examir	ner	4a. Facility Name (If not institution, give s				Location of Death	1		ounty of Death ontgomer	~~7	
194	Francis		Washington Advent  5. Social Security Number 6. Sex		birthday)	If Under 1 Year	ma Park If Under 24 Hrs.	8. Date of Bir (Month, Da		_	olace (State o	or Foreign
	Funeral Director			M 2⊠F 82	Yrs.	Months Days	Hours Min.	June 12			rdale,	
	TO .		Usual Residence of Decedent					70410 12	, 1,20			
	show	_	10a. State 10b. County	10c. City, To						1	0d. Inside Cit 1 X Yes	
	8a-f s	Sct 0	Maryland Prince Ge	eorge's Riv	erda							
	ill the	Ö	10e. Street and Number			10f. Zip Code	20737			en of What Cour JSA	itry?	
	s 232	Funeral Director	4801 Longfellow S	12. Was Decedent Ever in U.S.	10.1			necify Vee or No		. Race - Americ	ran Indian	
	item	Ē	11. Marital Status  1 ☐ Never Married 2 ☒ Married	Armed Forces? 1 ☐ Yes 2 ☑ No	13.	Vas Decedent of H f Yes, specify Cuba	an, Mexican, Puert	o Rican, etc.)		Black, White,		
936	urs af	Ş	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Ye ar or Dates:		I∐Yes 2⊠No	Specify:		S	pecify: Whi	lte	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ont, the "Midcal Evariant counts."	Completed	15. Decedent's Educ (Specify only highest grade	cation 1	6a. Dece	dent's Usual Occup	ation	kina	16b. Kind	of Business/In	dustry	
21	within 7 iene. t <b>han "r</b>	nple	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done of NOT use retired		ung	0	D - t		
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and	ould be fil Mental H arked otl atic ever	Be	17. Father's Name (First, Middle, Last)				Ruth Be		, iviaideri St	imame)		
Maryland	2 should be and Mental is marked craumatic ev	2	Ralph Macmichael  19a. Informant's Name/Relationship (Type)	no Brint)	IOh Moilir	g Address (Street			or City or T	Town State 7ii	n Code)	
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ē,	iges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the "doal Exament in the profile of an other traumatic event, the "doal Exament in the profile of an other traumatic event, the "doal Exament in the profile of an other traumatic event, the "doal Exament in the profile of an other traumatic event, the "doal Exament in the profile of an other traumatic event, the "doal Exament in the profile of an other traumatic event, the "doal Exament in the profile of an other traumatic event, the "doal Exament in the profile of an other in the profile of a second in the second in the profile of a second in the second in the profile of a second in the profile of a second in the sec		20a. Method of Disposition			sition (Name of natory or other place		Date		ation - City or To		
<u>ا</u>	ages ent of nt: If i		1 🔀 Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		ln Cemetery	1 = 100	3/2009	Bren	twood,	Marv1a	ınd
Baltimore,	permit. Pages 1 Department of I Important: If ite any Injury or ot		21. Signature of Funeral Service License			. Name and Addre		72005				
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			23a. Part 1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the death. I	Do not ent	er the mode of dyir	ng, such as cardia	or respiratory a	ırrest,		Approximate Interval Bet	tween
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2	/Medical		resulting in death)	Due to (or as a consequen	ce of):	, .	100:1	c 0				
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	ding h. Afte fune	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	Injury	Wor	k?  Yes 2 □No	Zou. Booonbo	non injury	55541154		
Division	Atten deat octor:	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home	, farm, str					Number or Rur	al Route Nun	nber,
Ē	al or s after od in b	Certification:	4 Homicide	building, etc. (Specify)				City or 10	wn, State)			
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier  (Check only 2 Medical Examin	sician: To the best of my knowle ner: On the basis of examination	dge, deat	n occurred at the ti	me, date and plac	e, and due to the	cause(s) a	and manner as	stated.	s)
	the Hin 24 the Fu	Medical	one)	and manner stated.	and/or in			aneo at the time				
	To the I within 2 To the I complete	Σ	29b. Signature and title of certifier			29c. Licens	se number		29d. Date	signed (Month,	Day, Year)	
			- unning	u, on		106	456		51	14	0	
10	7		30. Name and address of person who co	empleted cause of death (Item 23	Ba) (Type,	Print)	A//	TOLI	ma	Pur	K. n	D

State Registrar 31. Date filed (Month, Day, Year) MAY 2 7 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May 26, 2009 Year **Physician** 8:50 aM Padlan Feliciano Macaraeq /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Hospice-Casey House Rockville Montgomery 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, You 25, 5. Social Security Number 7. Age (In vrs. last birthday) Year) 1913 **Funeral** Days Hours Months 1**™** M 2□ F Philippines 350-52-0333 95 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director Maryland Montgomery Kensington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 10920 Connecticut Avenue 20895 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □Yes 2 K If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Asian <u>۾</u> 3₺ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medical Doctor Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marcela Prado Macaraeg Serapion Prado Padlan 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4006 Simms Drive, Kensington, MD 20895 Eduardo Padlan/Son permit. Pages 1 and Department of Health Important; If item 27 any injury or other troonce. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition May 26 2009 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd., W,. Silver Spring, MD 20901 21. Signalure of Funeral Service Licensee M60837 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Leaking Abdominal-Aortic Aneurysm /Medical Due to (or as a consequence of): Hypotension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Coronary Artery Disease, Atrial Fibrillation, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖔 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? Hypertension 24a. Was an autopsy performe 1 ☐Yes 2X No 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 1 No Hospital: Other:  $4 \square$  Nursing Home  $5 \square$  Residence 0.5Other (Specify) Hospice 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, after death Director: d in by the f

the Maryland

Pages 1 and 2 should be filed within 72 hours after death with nent of Heaith and Mental Hygiene.

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To the Funeral Di

Baltimore, Maryland 21215-0036

r than "natural", or items 23a or 28a-f show the Medical Expelher must be notified at

Certification: To 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) May 26, 2009 29c. License number 29b. Signature and title of certifier Kouchchou

State Registrar

31. Date filed (Month, Day, Year)



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			For State Registrar	State of Mai	ryland		rtment tificate			nd Me		giene Reg. No.	2111	9	186	555
14.	Physicia	an	1. Decedent's Name (First, Middle, Last) Maria G. Puglisi								2. Date of De Month May 22	ath Day		ear	3. Time of I	Death A M
	/Medic Examin		4a. Facility Name (If not institution, gives Anne Arundel Medic				4b. City,		Location of		May 22	4c.	County of			
	Funeral Director		5. Social Security Number 6. Sex		(In yrs. last	t birthday) Yrs.	If Under Months		If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da August	y, Year)		Birthpla Country	-	r Foreign
	D.	lor	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince Ge		10c. City, T		cation	e				,,			d. Inside Cit	
	with the	Direc	10e. Street and Number 3510 Oliver Street			- <b>y</b>	10f. Zip	Code	0782			10g. Citi	zen of Wha	at Countr	y?	
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Baltimore,	t. Page tment c tant: If tjury or		1 to Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 21. Signature of Fune al Service Licens		cerr	netery, crer of H	natory or o leaven	cemet			/2009	Silv	ver Sp	oring	g, Mar ore Av	-
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O. Box 6	eath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome p 1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal d	eath 3[	∃Ectopic pi ∃ Other (sp						23d. Date Mont		*	Year
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Division or	fune fune	Certification: 1	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injur (Month, Day	Year)	8b. Time o Injury	М		y at k? Yes 2 □ I	No	28d. Describe					
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	To the Hospital within 24 hours of To the Funeral completely filled	Medical	29a. Certifier (Check only one) 2 ☐ Medical Exam	sician: To the best of iner: On the basis of and manner sta	examination	on and/or ir	vestigation	n, in my o	pinion, dea	ath occurr	red at the time	, date ar	nd place, ar	nd due to	the cause(s	5)
	To the Com	Σ	29b. Signature and title of certifier			110	_		e number	175	_	29d. Da	ate signed	(Month, l	Day, Year)	9
A .	0 2		30. Name and address of person who o	ompleted cause of de	eath (Item 2	3a) (Type,		1	1571	9 73	12	U.	1.		200	1
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 10:15 AM Ernest Carol Reynolds, Sr. WAY 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Doctors Community Hospital Landover Prince Georges If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Hours Min. Voor Months Days 1 X M 2 □ F 65 Vrs 12/31/1943 231-54-3575 VA Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 XYes 2 No Prince Georges Glenn Dale 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10909 Legend Manor Lane 20769 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give 1963-67 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. African 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify 3 ☐ Widowed 4 ☐ Divorced American 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) National Gallery of Elementary/Secondary (0-12) 12 College (1-4or 5+) Art Protective Services 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Allen Reynolds Agnes Gerlene Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edna Hill Reynolds / Wife 10909 Legend Manor Lane, Glenn Dale, MD 20769 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/1/2009 Harmony Memorial Pk. Landover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service License 7400 Georgia Avenue, NW, Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final coronary artem multivessel disease or condition resulting in death) Due to (or as a consequence of): wites of silono Sequentially list conditions, if any, leading to minimaliate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): si abotes 120 11 Due to (or as a consequence of): imper tension IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 MANO 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No 24a, Was an autopsy performed? Yes 2 DANo 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 M ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, certificate After thi funeral of death. thin 24 hours after death.

the Funeral Director: A mpletely filled in by the fu within 2

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

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Physician/Medical

Completed by

Be

Certification: To

Medical

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(Check only

29b. Signature and title of certifier

29a. Certifier

MD

**Funeral** 

**Director** 

2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show

12 should be fi th and Mental H

Injury or other traumatic

permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau

**Physician** 

Maryland

Baltimore,

ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

2 200 +

> State Registrar

31. Date filed (Month, Day, Year)

m. Bollin

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



AUNAPOLIS ROAD SOITE ZZG GLENN DALE, MD

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0059981

29d. Date signed (Month, Day, Year)

21108

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 28, 2009 Month 8:00<sup>PM</sup> **Physician** George Thomas Robertson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9 Gills Hill Lonaconing Allegany If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) 6. Sex **Funeral** Days 1 M 2 □ F Maryland 80 216-22-6254 September 03, 1928 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

em 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Director Lonaconing Allegany Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21539 USA 9 Gills Hill Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) millwright 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ora Katherine Mowbray Thomas William Roberston 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17304 Hummingbird Hill, Lonaconing, MD, 21539 Sharon Nightengale - Daughter permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date May 29, 20c. Location - City or Town, State 1 ☐ Burial 2 ★Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland, Maryland Cumberland Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. 8 East Main Street Lonaconing, MD 21539 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Intracianial motastases undetermine 3 months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed and burial-trar Due to (or as a consequence of) physician a Box 68760. Physician/Medical attending ph IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the a 9 I Inknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 TYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy perform ormedy? certificate I 1□ Yes Division or Vital After this certification funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 [] inpatient 3□ DOA 2 ER/Outpatient Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred or Attending Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours at To the Funeral Di completely filled in Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Douglas Avenue, Lonacoing, mel 21539 MU eulin 20 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

JUN 01

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 11:34 A /Medical Laura L. Rawlings May 2009 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince Georges 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Year) 1 □ M 2 X F Hours Director 213-94-0020 45 January. 14. 1964 England Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at 1 □Yes 2 No Director Maryland Prince Georges Brandywine 10g. Citizen of What Country? 10e. Street and Number 12525 Cedarville Road items 23a 20613 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify Completed by Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) les 1 and 2 should be filed within 7 of Health and Mental Hygiene. If item 27 is marked other than "n or other traumatic event, the Median or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Professional Ouilter Self 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Phillip Hill Joan E. Burgart ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian Rawlings/ husband 12525 Cedarville Road, Brandywine, MD., 20613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 permit. Pages 1 Department of It Important: If ite any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Trinity Memorial Gdns May 27, 2009 Waldorf, MD.

22. Name and Address of Facility Huntt Funeral Home 21. Signature of Funeral Service Lice 3035 Old Washington Rd., Waldorf, MD., 20601 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on e.e.n in Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition u Inongi /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Our to for as a consequence of) the death certificate be executed sician and burial-tran Due to (or as a consequence of) Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) ned by the a 1 □Yes 2 □No Ö 9 Unknown ₫. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by sign 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 2 No 1 ☐ Yes Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the I within 2

3310 State 29b. Signature and title of certifier

30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signatu

Registrar

HD 20735

29c. License number

DOOUSILI

Michael Frasier

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 21 STAGGS **ELIZABETH KELLY** la /Medical 4c. County of Deat 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign
 Country) Hours **Funeral** APR. 24,2009 MARYLAND 27 Director NONE Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28a-f show notified at 1 ▼ Yes 2 □ No Directo HOWARD COLUMBIA MD. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code ö items 23a or ner must be n Funeral 21046 U.S.A. 7309 LITTLE BIRD PATH death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ☐ Yes 2 X No Yes, Give 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ò 1 Yes 2 No Specify: 2 Specify: 3 Widowed 4 Divorced Year or Dates WHITE 'natural" Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Medical (Give kind of work done during most of working life. DO NOT use retired) other than vent, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 0 NONE NONE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental 27 is marked of traumatic even **STAGGS** CLARISSA HART MARK 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other trainonce. 7309 LITTLE BIRD PATH, COLUMBIA, MD. 21046 MARK STAGGS/FATHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2x Cremation 3 Removal from State 5 Other (Specify) 4 Donation 5-26-2009 RIVERDALE, MD. CHAMBERS CREMATORY 21. Signature of Funeral Service Licensee CHAMBERS FUNERAL HOME & CREMATORIUM, P.A Mamber MOO091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Mulmonary **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) The law requires that the death certificate be executed DS1 burial-tra resulting in death) Last (or as a consequence of) physician a Box 68760. Physician/Medical RAITA IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 🗌 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has page ; 2 1 🗌 Yes 2 🗌 No certificate Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: 4 \subseteq Nursing Home 5 \subseteq Residence 1 🗌 Yes 1X Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) မ this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident (Month, Day 5 Pending investigation Injury 1 Yes 2 No death. I Director: A id in by the f 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a

To the Funeral Completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) ρ 30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print) Wal 600 North Wolfe St, Baltimore, MD, 21287 500 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 7

Registrar

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			Registrar  1. Decedent's Name (First, Middle, Last	")		imeate of	Death	2. Date of Dea	Reg. No. oth Day	3. Time of Death
	Physicia /Medica		ANNA NEAMON	SCORDAS				MAY	21	2009 3:10 A M
	Examine		4a. Facility Name (If not institution, give	street and number)			or Location of Death		4c. County	y of Death
•			3200 North Leisur			Silver If Under 1 Year	Spring If Under 24 Hrs.	B. Dota of Birt		gomery  9. Birthplace (State or Foreign
	Funeral	1	5. Social Security Number 6. Se	TM 2KTF	last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da June 28	y, Yea <i>r</i> )	Country) Canada
	Director	-	547-74-7315 Usual Residence of Decedent	94				Julie 20	9 1914	Canada
	land ow	-	10a. State 10b. County	10c. Cit	y, Town or Loc	cation				10d. Inside City Limits
	Mary Frsh	بَ	Maryland Montgom	erv Si	lver Sr	oring				1 ☐ Yes 2 🛣 No
	r 286	45 H	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Country?
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	ems erms	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. V	Was Decedent of f Yes, specify Cub	Hispanic Origin? (Sp pan, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Ra Bla	ice - American Indian, ack, White, etc.
22	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evarrine must be redified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1	1	I∐Yes 2⊠No	Specify:			ty: White
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2	ntal I ed of ed of	Be	Paul Neamon				Eleni	Petrov	ic	
Š	hould id Me mark matic	၉	19a. Informant's Name/Relationship (7	Type. Print)	19b. Mailir	ng Address (Stree	t and Number or Ru			n, State, Zip Code)
2	id 2 s Ith ar 27 is trau		Mary Anne Nasou/D							land 20895
5	f Hea	ŀ	20a. Method of Disposition	20b.		sition (Name of matory or other pla		Date		- City or Town, State
Daltimor	Page: tment o tant: If jury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	A A	lington	n Nat'l	Ceme 6/16			ton, Virginia
Da	permil Depar Impor any in		21. Signature of Funeral Service Liden	le co	1	1800 New	Hampshir	e Ave, S	Silver	NERAL HOME, INC Spring, MD 2090
			23a. Part 1. Enter the cisease, or companies shock, or heart faure. List only	olications that caused the dea one cause on each line.	th. Do not ent	ter the mode of dy	ring, such as cardiad	or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician		Immedia use (Final disease or condition	Myocardial						
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):					
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j	0 0 0	ysic	1 □Yes 2 🖾 No 9 □ Unknown	9 Unknown	death 31	Other (specify)				
7.	law requires that the deas been signed by the 2 should be detached		Part II. Other significant conditions of	ontributing to death but not re	sulting in the u	nderlying cause o	jiven in Part I.	23e. Did	tobacco use co	ontribute to the cause of death?
dS	uires sign Id be	d by	Hypothyroid	ism				1 🗆	Yes 2⊠ No	3 Probably 4 Unknown
Vital Records,	v req	Completed						24a. Was		b. Were autopsy findings available
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	ysicia s cer direct	o Be	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 ☐ Inpatient 2 [	☐ ER/Outpatie	ent 3 DOA	thor:	lome 5⊠ Res		Other (Specify)
ō	Attending Physician: If death. ector: After this certific by the funeral director,	Ë	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury		jury at ork?	28d. Describe	how injury occ	urred
0	endin ath. or: Af	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	n			□Yes 2□No			
Division of	i Pir e	Certification: To	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		home, farm, st cify)	reet, factory, offic	е	28f. Location City or To	(Street and Nu own, State)	mber or Rural Route Number,
_	pita urs eral		29a. Certifier 1  Certifying Pl	nysician: To the best of my kr miner: On the basis of exami	nowledge, dea	th occurred at the	e time, date and place	e, and due to th urred at the time	e cause(s) and	manner as stated.
	Hos Hos Hos Fund tely	1 ==	one)	and	Tation and/or i	nvestigation, in m	y opinion, acam coo			,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29b. Signature and title of certifier  W[ **R**********************************	and manner stated.			ense number			ined (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20901

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔈 🛭 🧍 🔾 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009ear May 24, **Physician** 4:07P. Schiavone Ethel C. /Medical a. Facility Name (If not institution, give street and number) Household of Angels Anne Arundel 4b. City, Town, or Location of Death Severna Park **Examiner** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Feb. 2,1915 9. Birthplace (State or Foreign 5. Social Security Number 389**–1**6–3790 **Funeral** Months Days Hours Min. 94 Wisconsin 1 □ M 2 🛛 F Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shouny or other traumatic event, It we Medical Examinations to so refined at 1 ☐ Yes 2 No Prince George's Beltsville Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20705 United States 4409 Usange Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 2 3X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Rediske Earl Colwell ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other trau once. 428 Yorkshire Drive Severna Park, Maryland 21146 John J. Schiavone, Jr. -son 20a. Method of Disposition

\*\*Disposition 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State George Washington Cemetery 5/28/2009 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Donald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, Maryland20705 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause ( disease or condition resulting in death) Aspiration Pheumonia Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 No 4 ☐ Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Old Cerebrovascular Accident; Dementia Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2X No certificate | 1 ☐Yes 2 X No 1 ☐ Yes 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Nother Assisted Lvg. 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

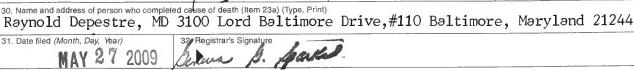
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only

. To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Aft completely filled in by the fur

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

7



MD

29c. License number

D27157

29d. Date signed (Month, Day, Year)

May 26, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 11:00 A **Physician** 2009 May Charles Frederick Seitz /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Charles | Waldorf 4885 Ouade Circle If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
May 21,1936 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, 6. Sex 1**X** M 2□ F **Funeral** Months Days Hours Min. Mary land Director 220-32-3814 72 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show 10a, State 10b. County Item 27 Is marked other than "natural" or items 23a or 28a-f show other traumatic event, the Madical Examination at the multiled at 1 ☐ Yes 2 No Director MD Charles Waldorf 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20602 4885 Quade Circle s 1 and 2 should be filed within 72 hours after death of Health and Mental Hygiene. Rem 27 Is marked other than "natural", or items 23: Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 □ Yes 2X No Specify. 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **Catterton Printing** Lithograph Stripper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Verna V. Wagner Charles F. Seitz 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MD 20602 4885 Quade Circle, Waldorf, Bettie J. Seitz Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 20a. Method of Disposition permit. Pages
Department of
Important: If its
any Injury or or 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 29,2009 Cheltenham, MD Maryland Vet. Cem. 22. Name and Address of Facility 21. Signature of Funeral Service **Huntt Funeral Home** M01284 3035 Old Washington Rd., Waldorf, MD 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 7/04/C - Work resulting in death) /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Esqueribally list or utilities, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine death certificate be executed burial-transi and Due to (or as a consequence of): ing physician as the burial Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 Other (specify) 0 ned by the a ☐Yes 2☐No 9 Unknown 9 ☐ Unknown signed by t σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 2 🗌 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performed.

1 Yes 2 No 1 ☐Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check o y one) Hospital: Other: 4 \sum Nursing Home ۵ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated

DB IDE State

Jean 31. Date filed (Month, Day, Year) MAY 27 2009 Registrar

29b. Signature and ti

30. Name and address

29431 Charlotte Hall Road, Charlotte Hall, MD.20622 Begistrar's Signatur

of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Pay, Year)

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 06 O1 Day 20ŎĠ 2:00 P M **Physician** MANUEL DONALD SHRINER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** ALLEGANY MOUNT SAVAGE 15128 MOUNT SAVAGE ROAD 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 11 10 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1916 MARYLAND 1 M 2 □ F 92 213-03-0333 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinal must be rediffied at once. 1 Yes 2 No Director MOUNT SAVAGE MD **ALLEGANY** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21545 15128 MOUNT SAVAGE ROAD Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Nes 2 No 1944 If Yes, Give Year or Dates: 1946 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: WHITE þ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TIRE MANUFACTURING MACHINIST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FANNIE MAY FORNEY SHRINER CORNELIOUS PETER SHRINER ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 15114 MOUNT SAVAGE RD NW MOUNT SAVAGE, MD 21545 CHARLOTTE MURPHY DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State MD MT. SAVAGE METH.CEM. 06-04-2009 MOUNT SAVAGE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOWERS FUNERAL HOME, P. A. 21. Signature of Funeral Service Licenses Han MO0 547 60 W. MAIN STREET FROSTBURG, MD 21532 SavaRS 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final STAGE RENAL DISEASE TRI Physician ENO disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) been signed by the should be detached 9 Dinknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has the autopsy performe 1 ☐ Yes 2 ☐ No 1 □Yes 2 12 No 25. Was case referred to medical 26. Place of Death (Check only one) director, Be Other: 4 ☐ Nursing Home 5 🗹 Residence 6 ☐ Other (Specify) 1∐Yes 2☑No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Tyre, Print) Robustiano Barrera 500 Memorial Avenue, Suite 201 Cumberland MD 21502 31. Date filed (Month, Day, Year) JUN 1 0 2009 37. Registrar's Signature State Barks Registrar

DHMH 17 Rev 1/2001

36

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician Bernice Suzie Sprouse 2009 May /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner 9. Birthplace (State or Foreign Country) tourney- Keedy Wa Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 □ M 2 🖫 F 92 Vrs 430-07-3408 15, 1917 Director Jan. Arkansas Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a, State 10b. County la or 28a-f show t be notified at 1 ☐Yes 2 XNo Director W17 Jefferson Harpers Ferry 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 25425 U.S.A. 128 Sprouse Lane d other than "natural", or Items 23a event, the Medical Examiner must t Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 10. 1 ☐ Yes 2 ☑ No Specify: White Completed by 3 Widowed 4 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) Computer Management Federal Government 12 Pages 1 and 2 should be filed vent of Health and Mental Hygie ant: If Item 27 Is marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Myrtle May Walton Beazley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 and 2 and 2 and 2 and Department of Health are Important: If item 27 is any injury or other trausonce. 8507 Mapleville Rd. Boonsboro, Maryland 21713 (Husband) Edwin C. Sprouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition June 2 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Smithsburg Crematory Smithsburg, Maryland 4 Donation 5 Other (Specify) 2009 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J.L. Davis Funeral Home M01414 12525 Bradbury Ave. Smithsburg, Maryland 21783 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Demention **Physician** LOY disease or condition resulting in death) /Medical Due to (or as a consequence of) Cardovascular Disage Examiner hertensing if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (a) as a consequence of) Examiner be executed and burial-tra Due to (or as a consequence of) attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 No P.O. the 9□Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed Yes 2 certificate 1□ Yes Division or Vital Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ YNo 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Inpatient within 24 hours after death.

To the Funeral Director; After this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital or 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 05-28-2009 022353 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Khalid Waseem 1126 Opal Crt. Hagerstown, Maryland 21740

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

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114

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32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) May 22, 2009 8:28 P M Teri Ulderigo 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Prince Georges Clinton Southern Maryland Hospital 8. Date of Birth (Month, Day, Year) Aug. 22, 1922 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Days Hours Washington, D.C. 1 ☑ M 2 ☐ F 578-07-3179 86 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 √ Yes 2 No Forestville Prince Georges 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20747 3809 Forestville Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☑Yes 2 □ No 1943− If Yes, Give Year or Dates: 1945 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🛛 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) U.S. Capitol Police Supply Sergeant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Utilia Gammarino Ferruccio Teri 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3809 Forestville Rd., Forestville, Md. 20747 / Wife Josephine M. Teri 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) June 9,09 Arlington, Va. Arlington National 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Juneral Service Licens 2222 Wisconsin Ave., NW., Washington, DC 20007 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 3 weel4 neumoura disease or condition resulting in death) recovent Plevral Effusion if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Severe anem Due to (or as a consequence of) Severe IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Year Month Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Fibrillations 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No Valoolic 1 □ Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

/Medical Examiner requires that the death certificate be executed physician and s the burial-trans Box 68760 attending p signed by the a o Д. Division of Vital Records, peen has certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

**Physician** 

/Medical

Examiner

10a. State

Director

Funeral

Completed by

Be

ပ

Examine

Physician/Medical

2

Completed

Be

Certification: To

ca

**Funeral** 

Director

s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene with the 17 st marked other than "natural", or items 23a or 28a-f show cother traumatic event, I've Musical Exprining in an less notified as

Baltimore, Maryland 21215-0036

Pages 1

permit. Pages 1 Department of H Important: If ite any Injury or ot once.

Physician

1 ☐ Yes 2 ☐ No 9 Unknown

25. Was case referred to medical examiner? 1 Tes 2 No

27. Manner of Death 1 Natural 2 Accident

3 Suicide

4 Homicide

5 Pending investigation 6 ☐ Could not be

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

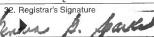
29b. Signature and title of ceraffie

29c. License number

29d. Date signed (Month, Day, Year) Upper Maulboro

Name and address of person who completed cause of death (Item 23a) (Type, Print) MW. G. CHAMP ALOU

31. Date filed (Month, Day, Year)



Registrar DHMH 17 Rev 1/2001

State

10+1

State of Maryland / Department of Health and Mental Hygiene For State Registrar AMEND#20bperFH, 5/28/09, BMW, McCo Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2009 3:48 p Nicholas Tangredi May 20, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Rockville eri Year | If Under 24 Hrs. Montgomery 13007 Vandalia Drive 8. Date of Birth (Month, Day, Jan. 3, 9. Birthplace (State or Foreign Country) New York 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1**⊠**M 2□ F Jan. Yrs. 1925 067-18-6771 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a State 10c. City, Town or Location r than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 ☐ XNo Director Rockville Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 13007 Vandalia Drive 20853 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ White 3 □ Vidowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Television Station Broadcast Technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be . Pages 1 and 2 should be file tment of Health and Mental H tant: If item 27 is marked off jury or other traumatic even Rose Conzo Antonio Tangredi ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other troonce. 13007 Vandalia Drive, Rockville, MD 20853 Margaret M. Fonseca/Daughter Baltimore, 27 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition May 28, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, Maryland Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2009 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd., W., Silver Spring, MD 20901 21. Signature of Funeral Service Ligensee Klekardt Gales 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** months Metastatic Bladder Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed burial-trar Due to (or as a consequence of): P,O, Box 68760 Physician/Medical use as the attending IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Year Day in the past 12 months? 5 Other (specify) □Yes 2□No detached 9 T Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖫 Unknown Renal Cancer, Lung Cancer, Diabetes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed Physician: The 1 ☐ Yes 2 ☐ No 1 □Yes 2 No 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🙀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After Hospital or Attending 1 🔀 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 124 hours after death.

te Funeral Director: A pletely filled in by the fu death. 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier completely (Check only one) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 22, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard Kurnot, MD 18109 Prince Philip Drive, #270, Olney, MD 20832 31. Date filed (Month, Day, Year) . Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** GRIFFITH THOMAS GIPSON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Plata Civista Medica (enter If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral X X** M 2 □ F Months Days Hours Director 217-18-5000 JAN.30,1922 MARYLAND 87 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f shov 1 ☐ Yes 2XXXIo Completed by Funeral Director MD CHARLES LA PLATA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9410 PENNS HILL ROAD 20646 U. S. A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2★No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married "natural", or If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify Specify: 3 Nidowed 4 Divorced WHITE Is marked other than "natur aumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. 12 ROUTE SALESMAN LANCE INC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GRIFFITH THOMAS ANNIE IDELLA NINER 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 ALLEN THOMAS / SON 13670 CHARLES ST. LA PLATA, MARYLAND 20646 permit. Pages 1 and Department of Heatth Important: If item 27 any injury or other to once. Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State TRINITY MEM.GRDNS. 12,2009 4 ☐ Donation 5 ☐ Other (Specify) WALDORF, MARYLAND Signature of Funeral Service 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. 5635 WASHINGTON AVE., LA PLATA, MD 20646 M00641 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MESTA **Physician** × MONTHS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ cate has been sign, page 2 should be 1 ☐ Yes 2 **N**No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 🗆 Yes 1 ☐ Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide

Box 68760, P.O. Division of Vital Records, To the Hospital

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated

State Registrar

Medical

20 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra/AMEND#5perFH6/4/09,BMW,McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Otis C. White May 2009 20 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Brooks Grove Reliabilitation and NURsing Center Spring Montgonery 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 1 A M 2 □ F 7. Age (In vrs. last birthday **Funeral** Months Days Hours Min. 86 Maryland Director May Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show if than "natural", or items 23a or 28a-f show 1X Yes 2 □ No Director Maryland Howard Highland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7629 Green Dell Lane 20777 United States of America Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1941–45 þ 1 ☐ Yes 2 🕱 No Specify Specify: White 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Principal Education and Mental Hygi 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Joseph White Beulah Todd ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra Brian White - Son 7629 Green Dell Lane, Highland, MD 20777 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park 05/26/09 Rockville, Marvland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilit lines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** preumonía days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner onagia weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner 7 heiners burial-tran resulting in death) Last Due to (or as a consequence of) ending physician use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant atter for u 3 Ectopic pregnancy in the past 12 months? Month Year Dav 5 ☐ Other (specify) Tyes 2 TNo per the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s this certificate 1 ☐Yes 2 ☐ No 1 ☐Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√2No Hospital: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral c 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death

To the Funeral Director;
completely filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

be executed Box 68760, P.O. 1 Division of Vital Records, Physician: or Attending

Hospital

2

Saltimore, Maryland 21215-0036

29a. Certifier

(Check only one)

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

School Road Sand

29d. Date signed (Month, Day, Year)

STAFF PHYSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gray Brook Huffman. 18100 Slade M-D-

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 2: 40P M **Physician** Elizabeth Weingart May 23 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3160 Gracefield Road, # 1231 Prince George's Silver Spring 8. Date of Birth (Month, Day, Yea June 28, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Days Hours Months New York 1 □ M 2 1 F 78 1930 Yrs. 103-24-6468 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Walted Example and the profiled at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ∐Yes 2X No Director Silver Spring Maryland Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20904 3160 Gracefield Road, #1231 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 X Married Specify: White 1 ∐Yes 2 🛣 No Specify <u>≨</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accounting Income Tax Preparer 17. Father's Name (First, Middle, Last)
Robert Alan Putney 18. Mother's Name (First, Middle, Maiden Surname)
Frances Mary Enright Be ( မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3160 Gracefield Road, #1231, Silver Spring, MD Joseph H. Weingart/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven
Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State May 25 2009 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 21. Signature of Funeral Service Licensee Francis Collins Funeral Home Inc. Moo837 500 University Blvd. W., Silver Spring, MD 20901 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neumonia **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 2 ☑No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 21 No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation

law requires that the death certificate be executed sician and burial-trans attending physician for use as the buria P.O. the ģ signed t Records, peen cate has t page 2 s certificate of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. Division

altimore, Maryland 21215-0036

29a. Certifier

(Check only

6 ☐ Could not be determined 3 ☐ Suicide 4 ☐ Homicide

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

13110 GRACEFIELD ROAD SILVERSPRING, MD LOVEEN J. PUTHUMANA

State Registrar

Medical

31. Date filed (Month, Day, Year)

When



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 | 8670

		For State			Certific	ate of	Death					Reg. No	D	. O O	J 100	_
Physician	1/ 1	e <b>gistrar</b> . Decedent's Name (First, Midd								2.	Date of D Month May 31,	eath Day 2009	Year		ime of Death 1312 hrs	
edical Examin		Connie Sue Wal a. Facility Name (if not institution	kefield	number)		141	o. City, Tow	n, or Lo	cation of I		,,	-	4c. County of	Death		7
	4	a. Facility Name (it not institute 702 Morris Avenue A		Humber)			Friends					-	Garrett			1
	4.	, Social Security Number	6. Sex	7 Age (Ir	n yrs. last bir	thday)	If Under 1	Year	If Under 2	24Hrs.	8. Date of	Birth (M	M/DD/YYYY)	9. Birthpla	ice (State or Foreig	ıπ
Funeral Director	5	215-84-2214	1 M 2X		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Yrs.	Months	Days	Hours	Min.	May	1,	1960	West	Virginia	a
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how ce.	١	MD Gar	rett		Frier	ndsvi	lle									$\dashv$
Maryland 28a-f show any d at once.	Director	0e. Street and Number					10f. Zip Co					10g. 0	Citizen of Wh		4	
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once.		702 Morris Av	enue, Ap	t 204				531				<u></u>	US		Indian Block	_
with th	<u>a</u>	11. Marital Status		Decedent Ev d Forces?	er in U.S.	13. Was	s Decedent es, specify (	of Hispa Cuban, I	anic Origir Mexican, F	n? ( Spe ⊇uerto F	cify Yes or Rican, etc.)	No-	14. Race White		Indian, Black,	
leath r item	uneral		viairieu 1 Ye	es 2 X	No	1		_					Specify:		hito	
after de II", or ner mu	J.		ivorced If Yes, Give	Year			Yes 2 X			and of the	ark dono	16	b. Kind of Bu		hite strv	-
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", c event, the Medical Examiner		15. Decedent's Education (Sp				. Deceden during mo	t's Usual Oc ost of workir	ng life. E	OO NOT u	se retire	ed)		D. 14114 01 - 0		,	- }
6 172 h an "n cal E	Completed	Elementary/Secondary (0-12	Colleg	ge (1-4 or 5+)	)   ,	Mursi	ng As	sist	tant			1	Nursin	g Hom	e	
withir iene.	Ĕ		1 -	10.				18	8.Mother's	Name	(First, Midd	le, Maio	den Surname	)		
15-( filed Hyg d oth		17. Father's Name (First, Middl							M	larg	aret	Loh	r			
21215-0036 ald be filed within 7 Mental Hygiene, marked other than c event, the Medica	B A	Floyd Wakefie 19a. Informant's Name/Relation	nship (Type, Print	)	- [1	9b. Mailing	Address	(Street	and Numl	ber or R	ural Route	Numbe	r, City or Tow	ın, State, Z	ip Code)	٦.
MD 2 d 2 shoul lth and N n 27 is n	۴	Floyd Wakefie	ld/fathe	r	<u> </u>	1285	Wakef	iel	d Rd.	., F	riend		lle, M			
re, MD 21, s. 1 and 2 should b f Health and Men If item 27 is mar'er traumatic eve	ŀ	20a. Method of Disposition				e of Dispos atory or ot	sition (Name	of cem	etery,		Date	2	0c. Location	- City or To	wn, State	
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.  ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoor other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 X Cremati		val from State	7		ide C	rem.		line	2, 2	009	Davi	dsvil	le, PA	
<b>E</b> 4 9 E F	-	4 Donation 5 Other 21. Signature of Funeral Servi	Specify: ce Licensee		TCOur		Name and A						eral H			
Balti permit. Departm Imports injury o	Ī	A Law	Dum!	210		112	79 Mil	ler	St.	Gr	antsı	/ill	e, MD	21536		
Physician	-	23a. Part I Enter the disease,	or complications t	hat caused th	ne death. Do	not enter t	he mode of	dying, s	such as ca	ardiac o	r respirator	y arrest	, shock, or he	eart	Approximate Interv Between Onset ar	
Medical		failure List only one cau Immediate Cause (Final disea	se on each line.												Death	4
aminer	- 1	or condition resulting in death		as a conseq	quence of):											
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	ie.	if any, leading to immediate cause. Enter Underlying Cau	se	r as a consec	quence or).											_
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Box e death c the atten ed for us	Physic	1 100 2 4 110 5		Unknown										4-1h-14-4-4-4	he cause of death?	,—
<b>∵</b> ‡ 55		Part II. Other significant cor	nditions contribu	ting to death	but not resu	Iting in the	underlying	cause (	given in Pa	art I.					ably 4 Unknov	
ords, P.O. w requires that the second of the	d by										1,550	Was a		C	opsy findings availa	
rds requi been hould	ete										244	autops	у	prior to co	ompletion of cause	of
Reco The law cate has	Completed										1 🗸	Yes 2		1 Ye	s 2 No	,
zal Re(ian: The certificate		25. Was case referred to med	dical					26.Place			only one)					
/ita /sicia nis cer direct	Be G	examiner?	Hospital:	1 Inpatie	nt 2 El	R/Outpatie	nt 3 D	AOA	Other <sub>4</sub>	Nursi	ing Home		Residence 6		: Scene	
vision of Vital Records, or Attending Physician: The law requir fler death. Director: After this certificate has been s in by the funeral director, page 2 should l	2 2	27. Manner of Death	28a	. Date of Inju (Month, Day, Y		8b. Time o	f Injury	_	ury at Wor		28d. De: Precipt	scribe h tated f	ow injury occ rom heigh	urrea 1t		
On ending ath.  or: A the function	흝		ending	(Month, Day Y ay 31, 2009		305 hrs		-	Yes 2 ₩		1				rei Pouto Number	City
Division tal or Attendii rs after death.	Certification:	7.00.00	Could not be	e. Place of In	jury - At hom	e, farm, st	reet, factory	, office	building, e	etc.	28f. Loc or T	own, St	treet and Nul ate) enue Apt. 2	nder or Ru	ral Route Number,	Oity
Divis  sppital or A  hours after  meral Dire  y filled in b	er	4 Homicide		pecify) Mu												
# 4 F 5		29a. Certifier 1 Certifyin	g Physician: To t	the best of m	y knowledge	, death occ	curred at the	e time, c	date and p in, death o	lace, ar	nd due to th at the time	ne cause e, date a	e(s) and man and place, ar	ner as stati id due to th	e cause(s)	
To the Hos within 24 h To the Fur completely	Medical		and ma	basis of exai	mination and	, or mivesus			se numbe				29d. Date s	igned (Mo	nth, Day, Year)	
	Ž	29b. Signature and title of ce	ertifier	, /			29		.M.E.				June 1,			
			M.	le												
_	2	30. Name and address of pe	rson who complete Deputy Chief	ed cause of d	death (Item 2 Syaminer	3a) 111 P	enn Stre	et. Ba	altimore	, MD 2	21201					
	5				ar's Signature		- 2									
	State	31. Date filed (Month, Day Y	TOOO	Z. I Cylotto	J. J.g. Midic	par	5									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009

**Physician** /Medical **Examiner** 

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Exercitive intel be southed at once.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and "completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

•	For State Registrar	State of I	viai y iai ic	•	tificat				TOTILA		g. No. 2 (	009	188	571
	1. Decedent's Name (First, Middle, L	.ast)							2. Date Mon	of Death	Day	Year	3. Time of I	Death
n al	Mary Julie	tte W	hite								2009		8:00	a M
er	4a. Facility Name (If not institution, g	give street and numb	er)		4b. City,	Town, or	Location	of Death			4c. Count	ty of Death		
	St. Mary's Hospi					nard			,				ary's	
	Social Security Number     6.	Sex 7.	Age (In yrs. la	-	If Under Months	1 Year Days	If Under Hours	Min.	(Moi	of Birth oth, Day,		9. Birth	place (State or Intry)	Foreign
	220-38-3668	TOW ZIA	83	Yrs.					May	18,	1926_		Mary	land
	Usual Residence of Decedent  10a. State 10b. County		10c, City	Town or Lo	cation								10d. Inside Cit	y Limits
ŏ	,												1 □Yes	2 🔀 No
ect	Maryland St.  10e. Street and Number	Mary's		Leona	rdtov 10f. Zip					10	g. Citizen of	What Cou	intry?	
ā					101. 210					"				
Be Completed by Funeral Director	21585 Peabody	Street_	nt Ever in II S	12 1	Mas Docor	206		igin2 (Sn	acify Vas	or No	U S		ican Indian,	
Š	11. Marital Status	Armed Force	es?	. 13.	Was Deced f Yes, spec	cify Cubar	n, Mexica	n, Puerto	Rican, e	tc.)		ack, White		
y.	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	If Yes, Give	T		1 □Yes	2 <b>X</b> No	Specify	:			Spec	ify: B	lack	
ed I	15. Decedent's			16a. Dece	dent's Usua	al Occupa	ation		-	1	6b, Kind of	Business/I	ndustry	
Set	(Specify only highest	grade completed)		(Give	kind of wo. DO NOT us	rk done d se retired)	uring mos	st of work	ing				ŕ	
Ē	Elementary/Secondary (0-12)	College (1-4	or 5+)		omema						Owr	Home	е	
ပို	17. Father's Name (First, Middle, La	st)					18. Moth	er's Nam	e (First,	Middle, M	laiden Surna	ame)		
	Unknown					į	М	vrt1	.e	L		Brya	n	
မ	19a, Informant's Name/Relationship	(Type Print)		19h Mailir	na Address	(Street a		<i>y</i> -		Number.	City or Tow			
											y1and			
	Raymond D. Whit	.e/5011	20b. Pl	lace of Dispo					Date		Oc. Location			
	1 ☑ Burial 2 ☐ Cremation 3		316	_			i				Saa	tland	MD	
	4 □ Donation 5 □ Other (Spe		St	Luke					8/20					
1,	21. Signature of Funeral Service Lic	14	2										me, P.A	<i>1</i> •
	Kyle Simons	M01206/2					-					n, MD	20650	
	23a. Part 1. Enter the disease, or co shock, or heart failure. List or	omplications thet cau ily one cause on ea	sed the death h line.	. Do not ent	ter the mod	de of dying	g, such a	s cardiac	or ræpir	atory arre	est,		Approximate Interval Bet Onset and I	ween
	Immediate Cause (Final disease or condition	_e -	cul	2 Co	ona	nu	EN	EM	1				men	elss
	resulting in death)	Due to (or	s e consequ	ence of):	1	4			<	4 4				
	Sequentially list conditions	b	120	nar	411	WE	241	KK	East	2			YEDE	24_
ne.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Zue to (or	as a consequ	ienca of).	1		/ ~						()	
am	that initiated events	с			<u>/</u>									
ŭ	resulting in death) Last	Due to (or	as a consequ	ience of):										
edical Examiner		d												
Jed	IC CEMALE.										$\top$			
Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregna th 2  Fetal		☐ Ectopic p	oregnancy	,					Date of del Month	,	Year
<u>S</u>	in the past 12 months? 1 ☐ Yes 2 <b>@</b> No		nt at time of d		Other (s						'	VIORIEI	Day	rear
hys	9 🗆 Unknown	3 LI OTIKION	v11						-1-					2
Σ	Part II. Other significant condition	s contributing to dea	th but not resu	ılting in the u	nderlying o	cause give	en in Part	1.	23	e. Did tob	acco use co	ontribute to	the cause of c	leath?
b D	- A						1 □ Ye	s 2 No	3 □ Pi	robably 4 ☐ \	Jnknown			
é	() calvela	1 Moll	lus						24	a. Was ar		b. Were au	itopsy findings	available
Ĕ	- Charles	4/1000								autops	ned?	death?	completion of c	ause or
ರ್ಷ	25. Was case referred to medical				oe Die	o of Dec		⊒Yes 2 konlyon	No No	1 ∐ Yes	2 □ No			
Be	examiner?  1 Yes 2 No	Hospital:	patient 2	ED/0.4-+#:	nt 2 🗆 🗆	Othe	Dr.				ence 6 🗆 (	Other (C-	oifu)	
۲. ۲.	27. Manner of Death	28a. Date of		28b. Time of				iursing H			w injury occ		uny)	
io	1 Natural 5 ☐ Pending	(Month	Day, Year)	Injury	м	28c. Injur Work 1 □	(? Yes 2[	]No	-3=.50		,,			
Sa	3 ☐ Suicide 6 ☐ Could no		me farm et			.55 -1		28f. Lor	ation (St	reet and Nu	mber or Ri	ural Route Nun	nber.	
Ŧ	4 ☐ Homicide determin	ed building	f Injury - At ho , etc. (Specify	y)	Jos Idolo	,, onioo			Cit	y or Towr	, State)			,
<u>త</u>	29a. Certifier 1 Certifying	Physician: To the b	ant of my ken	wladae des	th occurre	d at the fir	me date	and place	and du	e to the o	ause(s) and	manner a	s stated	
S	(Check only one)	caminer: On the bas	is of examina	tion and/or in	nvestigation	n, in my o	pinion, de	eath occu	rred at th	ne time, d	ate and plac	e, and due	e to the cause(s	s)
Medical Certification: To	Λ	and manne	er stated.		20	le Licene	e number			2	9d Date sin	ned (Mont	h, Day, Year)	
_	29b. Signature and title of certifier	DI	0	MIT	1 29	c. Licens	) O	1111	Q.	2	/ Late sig	1 - 1	9	
	bing	ST. bus	NOE	MAT	الب	W	UE	241	/		0-0	ト	/	
	30. Name and address of person w	ho completed cause											•	
	Tampe 19 Tari	haa M/D	240	135 Th	ree N	otch	Rd.	- Ho	11 vvv	ood -	MD 20	636		

State Registrar

31. Date filed (Month Day, Year) JUN 0 3 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 86/ Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 4:54AM **Physician** 50 M 7-200 eanne -vances /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner eci ion Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 04-03 -7. Age (In yrs. last birthday) cial Security Number **Funeral** Days 122-26-7858 1 □ M 2 X F Director Usual Residence of Decedent 10d. inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1. Yes 2 □ No Director Rising 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Funeral Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No altimore, Maryland 21215-0036 Specify Completed by 3 ☐ Widowed 4 Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2 ROOD even 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 D.Cremation 3 □Removal from State Newark Services 5 ☐ Other (Specify) 4 ☐ Donation 21. Signature of Funeral Service Licensee ddress of Facility Name and ramily Churchmens 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Rulmonary Disease Immediate Cause (Final disease or condition resulting in death) unknown **Physician** /Medical Due to (or as a consequence of) unknown Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>6</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an autopsy performed 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Tyes 2 ER/Outpatient 3 DOA Certification: To this completely filled in by the funeral 27. Manner of Death 1 2 Natural 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? within 24 hours after death. To the Funeral Director: After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 • Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and titlen f certifier

Registrar
DHMH 17 Rev 1/2001

State

126 A

Sachder S MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 135AM 2009 me /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Year, April 24, 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months Days Hours 1 □ M 2🏋 F 35 218-04-5729 Georgia 1974 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City Town or Location 10a. State 10b. County 28a-f show or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 1 Tyes 2X No Silver Spring Director MD Montgomery 10e. Street and Numbe 10f. Zip-Code 10g. Citizen of What Country? 20904 USA 12743 Turquoise Terrace Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo 14. Race - American Indian Black, White, etc. Never Married 2 Married 1 Yes 1 Yes 2 No Specify: Black þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) US State Department Executive Assistant 18. Mother's Name (First, Middle, Maiden Surname) traumatic event, 17. Father's Name (First, Middle, Last) Be and Mental Roger C. Braxton, Jr. Mattie D. Spence ဂ Father 1 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other trauonce. 7009 Massaponax Church Rd. Virginia 22551 Mr. Roger C. Braxton, Jr. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 💆 Burial 2 🗌 Cremation 3 🗍 Removal from State cemetery, crematory or other place) Spotsylvania, VA 6-6-09 Sylvannah Bapt Church 4 Donation 5 Other (Specify) 21. Signature Funeral Service Licensee A.L. Bennett Funeral Home, Inc. 200 Butternut Drive Fredericksburg, VA nd Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a Part | Enter the disease or heart failure. List only one cause on each line. Immediate Cause (Final CEREBRITIS LUPUS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** UPUS Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) physician and s the burial-tran Due to (or as a consequence of): Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy atter for in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) signed by the att 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 TYes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2**X**No 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 XInpatient Other: 4 $\square$ Nursing Home 5 $\square$ Residence 6 $\square$ Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Year) Injury 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined

The law requires that the death certificate be executed Box 68760, Division of Vital Records, P.O. filled in by the funeral ol or Attending Paratter death.

Baltimore, Maryland 21215-0036

24 hours a Funeral D Hospital 

4 Homicide

(check only

29b. Signature and title of certifier

31. Date filed (Month. Day, Year

29a, Certifier

Medical

MEDICAL DOCTOR

29c. License number RES - 000

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) 29d. Date signed (Month, Day, Year)

JUNE , 02, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

RANGACHARI JOHNS HOPKINS HOSPITAL 600 North Wolfe St, Baltimore, MD, 21287 THE

State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** THOMAS FENTON BOLTON, SR. JUNE 2009 5:30 A M 6 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Mandarin Hospice House Harwood Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 11☑ M 2□ F 88 Director 213-16-4250 3, Apr. 1921 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the "Adical Formings must be notified at 1X Yes 2 No Director MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Bay Front Drive, #202 21403 Funeral death USA permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ :-- any injury or other traumatic average. 12. Was Decedent Ever in U.S. Armed Forces? 1XXX es 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th Firefighter BWI Airport Fire Dept. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မှ Harry Thomas Bolton Leola Virginia Carter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gladys R. Bolton/Spouse 7101 Bay Front Drive, #202, Annapolis, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, MD Veterans Cemetery 6/12/2009 22. Name and Address of Facility Donaldson Funeral Home, 21. Signature of Funeral Service Licensee - Kein M01053 313 Talbott Avenue, Laurel , MD 20707 Approximate Interval Between Onset and Death 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Cerebrovascular Disease 3 months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No P.0. 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð cate has been signated by page 2 should b Hypertension, Dementia, Cardiovascular Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒No 24a. Was an certificate 1 ☐ Yes 2 🔯 No Division of Vital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 10ther (Specify) Hospice ျပ 1 ☐ Yes 2 🛛 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Pending 24 hours after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) within 2 and manner stated. 29b. Signature and title of certifier 29c. License number completed cause of death (Item 23a) (Type, Print) Name and address of 32. Registrar's Signature Date filed (Month, Day, State JUN 1 1 2009 Registrar DHMH 17 Rev 1/2001

		1 - For State Registrar	Olaic o	i iviai yiain		ertificate of		, ,	g. No. 20	09 18	1675
Dhusisi		1. Decedent's Name (First, Middle	, Last)					Date of Death     Month			of Death
Physici Medio/		Betty M	arie Be	nnett				June 8	, 2009	8:24	P <sup>M</sup>
Examin		4a. Facility Name (If not institution	, give street and nur	mber)		4b. City, Town, o	r Location of Death		4c. County	of Death	
		Regency Park As	sisted Li	ving		Crof	ton		Anne	Arunde1	
uneral			6. Sex	7. Age (In yrs. la	ast birthda	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Birthplace (State Country)	e or Foreign
irector		283-16-7426 Usual Residence of Decedent	1 □ M 2 □ XF	90	Yrs.			Dec 20,	1918	7 Ohi	io
how		10a. State 10b. County		10c. City	, Town or	Location				10d. Inside	
a-f s	Director	Maryland Anne	Arunde1		Gan	mbrills				1 □Ye	s 2 No
or 28	ie	10e. Street and Number				10f. Zip Code		10	g. Citizen of V	What Country?	
23a c		730 Maryland R	t 3 South	1		210	54		Unit	ed States	
sms	Funeral	11. Marital Status	· · · · · · · · · · · · · · · · · · ·	dent Ever in U.S	S. 13	3. Was Decedent of H	lispanic Origin? (Spe	ecify Yes or No-		ce - American Indian,	
or ite		1 ☐ Never Married 2 ☐ Marri	ed 1 Tes	2 <b>Z</b> INo		1 □Yes 2 No	Specify:	riicari, etc.)		ck, White, etc.	
Iral",	d by	3 XWidowed 4 □ Divorced	Year or D	ates:					Specify	White	
"natı	lete	15. Decedent (Specify only highes	s Education t grade completed)		(Giv	cedent's Usual Occup ve kind of work done	during most of worki		6b. Kind of Bu	usiness/Industry	
Important; if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Micrical Examinat must be notified at once.	Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)	iire	. DO NOT use retired Homemaker	,	l.	Over	n Home	
other ent, t	Be Co	17. Father's Name (First, Middle, L	<u> </u>			Homemaker	18. Mother's Name	(First, Middle, M			
ked c	To B	Ralph Cecil	White				Marth	a Elizab	eth Ar	ndt	
паг лтаt	-	19a. Informant's Name/Relationsh			19b. Ma	iling Address (Street					
27 is r trau		Maureen B. Berg		or		) Elsa Ave		dorf, Ma			
iten		20a. Method of Disposition	cr/ daugne	20b. PI	ace of Dis	position (Name of	, .		<del></del>	City or Town, State	
nt: If		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		State	-	ematory or other place l Veterans		2/2009	Crowns	ville, Man	rvland
ortar inju		21. Signature of Funeral Service L		rat							y Land
E a a		Juanita R	Domar	м009	57   I	22. Name and Addre Donaldson  411 Annap	Funeral H olis Road	ome & Cr Odenton	emator Marv	y, P.A. land 21113	3
		23a. Part Enter the disease, or	complications that c	aused the death						Approxim	ate
sician		shock, or heart failure. List of Immediate Cause (Final								Interval B Onset and	d Death
edical		disease or condition resulting in death)	a	oke or as a consegu	ence of):					5 yea	ars
miner				ial Fib		+100				F	
	ē	Sequentially list conditions, if any, leading to immediate		or as a consequ		CIOII				5 yea	115
ansit	Examiner	Cause (Disease or injury that initiated events									
an an rial-tr	Ĕ	resulting in death) Last	Due to (	or as a consequ	ence of):						
ng physician and as the burial-transit	Medical		d								
ng ph as th	led	is several s	1		_				1		
endil	Į.	IF FEMALE: 23b. Was decedent pregnant		come of pregnar		B Ectopic pregnanc	44		23d. Dat	te of delivery	
ed for	Physician/	in the past 12 months? 1 □ Yes 2 🗷 No		nant at time of de		Other (specify)	У		Mo	onth Day	Year
by the	چّ	9 □ Unknown	9 0 0 0 0	OWII				T			
gned se de	by	Part II. Other significant condition	ns contributing to de	eath but not resu	Iting in the	underlying cause giv	en in Part I.	23e. Did tob	acco use cont	tribute to the cause o	f death?
en si								1 ☐ Yes	s 2X∏ No	3 Probably 4 □	Unknown
as be	Completed							24a. Was an		Were autopsy finding	
ate h	ē							autopsy perform 1 □Yes 2.	ed?	prior to completion of death? 1 □ Yes 2 ☎ No	i cause oi
ertific ctor,	Be (	25. Was case referred to medical					26. Place of Death	-			
nis ce	2	examiner? 1 ☐ Yes 2 📉 No	Hospital: 1 ☐ 1	npatient 2 🗆 E	ER/Outpati	ent 3 DOA Oth	er: 4 🗆 Nursing Ho	me 5 ☐ Resider	nce 6 XOth		ișted
fter th	ü	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date	of Injury h, Day, Year)	28b. Time Injury		y at k?	28d. Describe how	w injury occurr	red	<del>/1ng</del>
or: A	ati	2 ☐ Accident investiga	ation			M 1 □	Yes 2 □ No				
irect n by 1	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Place	of Injury - At hor ng, etc. (Specify	me, farm, s	street, factory, office	1	28f. Location (Str. City or Town,	eet and Numb , State)	per or Rural Route Nu	umber,
led ii		17	1								ļ,
To the Funeral Director: After this certificate has been signed by the attendir completely filled in by the funeral director, page 2 should be detached for use	Medical	29a. Certifier  (Check only one)  1. Certifying 2	xaminer: On the ba	best of my knov asis of examinat er stated.	vledge, de ion and/or	ath occurred at the ti investigation, in my o	me, date and place, ppinion, death occurr	and due to the ca red at the time, da	ause(s) and ma ate and place,	anner as stated. and due to the cause	e(s)
o the	Mec	29b. Signature and title of certifier	3	Pristated.		29c. Licens	e number	29	od. Date sidne	d (Month, Day, Year)	
F 8		· 6/1/11	TR	100			0094		Elic	1.0	
0		20 Name and address of second	1 /J	0 0	00-) (7				שונט	104	
6		30. Name and address of person (						OD 61	, l	36.	1 0107
Stat	te	Elliott Gorbat 31. Date filed (Month, Day, Year)		a mindre ola Olamak			e, Suite	ZR Glen	Burnie,	, Maryland	1 21061
Registra		JUN 1 1 200	43	w B.	par	الما					
		LUU	~ /		AT .						

			For State Registrar	State of Mar		rtificate of			Reg. No.	09	18676		
e	Physici	an	1. Decedent's Name (First, Middle, Las Robert Kenneth Bi					2. Date of De Month	Day	Year	3. Time of Death		
	/Medic	al	4a. Facility Name (If not institution, give			4h City Town o	r Location of Death	June	4c. Cour	2009 nty of Death	11:00 A <sup>M</sup>		
C-	Examin	er	626 S. Newkirk St.			Baltim				/a			
p g	Funeral Director		217-02-3744	ex M∑M 2□F 7. Age (i	In yrs. last birthday 54 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da March	th 23,1955	9. Birthp Cour Vil	olace (State or Foreign otry) Cginia		
	and w t		Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Town or L	ocation				1	Od. Inside City Limits		
	Maryl t-f sho fied a	tor	Maryland n/a		Baltimo	ore					1 XYes 2 □ No		
	th the or 288 e noti	Sirec	10e. Street and Number			10f. Zip Code			10g. Citizen o		•		
	ath wi	ral	626 S. Newkirk St.			2122				d Stat			
21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland not Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed by Funeral Director	11. Marital Status  1   Never Married 2   Married 3   Widowed 4   Divorced	12. Was Decedent Eve Armed Forces? 1 N Yes 2 No If Yes, Give Year or Dates:	74-77	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ▼ No	an, Mexican, Puerl	o Rican, etc.)	Spe	lack, White,	etc.		
5-0	72 ho 'natur dical l	eted	15. Decedent's Ec (Specify only highest gra	lucation de completed)	16a. Deci	edent's Usual Occup e kind of work done DO NOT use retire	nation during most of wor	rking	16b. Kind of	Business/In	dustry		
121	within ane. than "	du	Elementary/Secondary (0-12)	College (1-4or 5+)	I .	DO NOT use retire nachinist	d)		aeros	oace			
	filed v Hygie other		17. Father's Name (First, Middle, Last,	)		Idelititibe	18. Mother's Nar	ne (First, Middle					
<u>Ilan</u>	uld be Mental Irked Itic ev	To Be	James Jacobson				Nancy St	ubbs					
, Maryland	1 and 2 should be filed within ' Health and Mental Hygiene. em 27 Is marked other than "' ither traumatic event, the Mec		19a. Informant's Name/Relationship ( Daniel Billiat/br	other	143	ing Address (Street Olen Dr.	Glen I	ural Route Numb Burnie,		vn, State, Zij 061	Code)		
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Hemoval from State	-	osition (Name of ematory or other pla nt Cremato		Date 7 – 09	20c. Location Balti	•	own, State Maryland		
Balti	permit. Pages : Department of H Important: If ite any injury or of once.	21. Signature of Funeral Service Licensee  John O. Mitchell IV, Funeral Services of 1  200 E. Padonia Rd. Timonium, MD 210											
	The sale		23 Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line.	e death. Do not ei	ter the mode of dyi	ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Between		
4	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Colon							Onset and Death  2 min the		
<b>A</b>	/Medical Examiner		resulting in death)	Due to (or as a c	consequence of):								
	6. 1	ler	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c	consequence of):								
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C									
90,	oe exe cian al ourial-t	I Ex	resulting in death) Last	Due to (or as a o	consequence of):								
68760,	icate b physic the b	edical		_d									
Box	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the bunal-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No	23c. If yes, outcome pf 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death 3	□Ectopic pregnanc	у		23d.	Date of deliv Month	ery Day Year		
P.0	that the de led by the a detached f		9 ☐ Unknown  Part II. Other significant conditions	contributing to death but	not resulting in the	underlying cause giv	ven in Part I.	23e. Did	tobacco use c	ontribute to t	he cause of death?		
ds,	w requires that s been signed t should be deta	d by		,		, , , ,		1 🗆	Yes 2□ No	3 □ Pro	bably 4 Whiknown		
000	s beer shou	Completed	W.					24a. Was	an 24	b. Were auto	opsy findings available		
R	siclan: The law certificate has b irector, page 2 s	Juo:		-				auto perf 1⊟ Yes	ormed?	death?			
/ita	clan: ertifica	Be C	25. Was case referred to medical examiner?					ath (Check only					
or/	Physi this c	은	1 Yes 2 No  27. Manne of Death	Hospital: 1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpation	SIIL 3 LI DOA	ner: 4 Nursing h	dome 5 ☑ Res 28d. Describe	how inlunt oc		fy)		
O	ding h. After funer	tion	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day \	/ear) Injury	Wo	rk? ]Yes 2 □ No	200. Describe	now injury oc	curred			
Division or Vital Records,	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of injury building, etc.	r - At home, farm, s (Specify)	treet, factory, office		28f. Location City or To	(Street and Nu own, State)	mber or Rur	al Route Number,		
	lospita hours unera		29a. Certifier (Check only 2 Medical Exa	nysician: To the best of miner: On the basis of e	my knowledge, dea	ath occurred at the t	ime, date and plac	e, and due to the urred at the time	e cause(s) and	manner as	stated. to the cause(s)		
	the L	Medical	29b. Signature and title of certifier	and manner state		29c. Licens			29d. Date sig				
	Mil 8	_	205. Signature and title of certiflet	3/CH.	MA								
	5		30. Name and address of person who	completed cause of dea	th (Item 23a) (Type		70 30 0		JUNE	1 20			
,	V		FREDERICK B. K			LEENE ST	utin 1	BAZTHIM	E MAN	y LAN.	0 2120/		
\$**	Sta Registr		31. Date filed (Mörith, Day, Year)	32. Negistrar'									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3:20 A M **Physician** Evelyn Borden 2009 June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Overlea Health & Rehab. Center **Baltimore** If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours Months 1 □ M 2 🔀 F 95 March 1,1914 NewBedford,MA Director 027-20-4783 Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and I filem 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or other traumatic event, The Medical Examiner must be notified at uny or other traumatic event, The Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 1X Yes 2 No Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21206 6116 Belair Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married White 1 ☐Yes 2X No Maryland 21215-0036 Specify ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Cotton Mills Elementary/Secondary (0-12) College (1-4or 5+) Seamtress 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertha Maude Robinson Clarence Lawton Borden ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Wilhelmina Borden/Sister in Law 2911 Second Avenue, Parkville, MD 21234 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Evans Funeral Chapel 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 06/10/09 Borest Hill, MD permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Bel Air 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Service
8800 Harford Rd. Parkville, MD 21234 21. Signature of Funeral Service License 23a. Par 1 Enter the disease, or complications the aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause and each line. Approximate Interval Between Onset and Death Im hedi te Cause (Final **Physician** disea e or condition res fling in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that influence are injury) Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Box 68760, 8Due to (of Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🌠 No 5 Other (specify) signed by the a d be detached for 0 9 Unknown 9 Unknown ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 1 ☐Yes 2 ☐ No 1 ☐Yes 2 XNo certificate of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Division 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3 och Raven Blad. of person who completed cause of death (Item 23a) (Type, Print) 560 2 32. pegistrar's Signature 31. Date filed (Month, Day, State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 6 **Physician** Margaret T. Bailey /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** SAMA Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs Security Number 6. Sex 7. Age (In yrs. last bil thday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🕅 F Months Days Hours 214-24-7703 81 Director 09/30/1927 Baltimore, MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the Modical Examination must be notified at Baltimore Director MD Baltimore 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2907 Conroy Court Apt. B 21234 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 Married 1 ∐Yes 2√ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify: White \$ Specify. 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. C&P Telephone Elementary/Secondary (0-12) College (1-4or 5+) 12 Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ages 1 and 2 should be file out of Health and Mental H t: If item 27 is marked oth Be Herman Baumgartner Gertrude Ryan ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21234 19a. Informant's Name/Relationship (Type. Print) 2907 Conroy Court Apt. B, Baltimore, MD Stanley Bailey/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens Of Faith Pages 1 20a. Method of Disposition Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State ò 06/10/09 |Rosedale, MD permit. Page Department of Important: If any Injury or once. 4 Donation 5 Dother (Specify) Cemetery 21. Signature of Funeral Service Licensee E<sup>22. Name and Address of Facility</sup> Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 23 . Parl 1. Enter the disease, or complications that caused the denock, or heart failure. List only one cause on each line. I nmediate Cause (Final **Physician** see se or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami burial-trar Due to (or as a consequence of): physician Physician/Medical the attending pt IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 more Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) P.O. g Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 : autopsy performe certificate of Vital 2 No 1 ☐Yes 2 ☐No i∏Yes Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this မ funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After Division 5 Pending death. investigation 1 ☐ Yes 2 ☐ No To the Funeral Director: completely filled in by the 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) or A 4 Homicide within 24 hours a To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signatu and title of certifier 29d. Date signed (Month. Dav. Year)

Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

eveny Ann bai		1- For State of Maryland / Department of Health and Mental Health Registrar  Certificate of Death		g. No. 201	09 18679
Physici Medical Exami		Decedent's Name (First, Middle, Last)	2. Date of Death Month May 21, 20	h	3. Time of Death 0623 hrs
ileuicai Exaiii	Hei	Beverly Ann Bartos  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Deatle		4c. County of D	
		3128 Baybriar Road  5. Social Security Numberum & 6. Sex  7. Age (In yrs. last birthday)  If Under 1 Year   If Under 24Hr	a le Data of Birt	Baltimore	County  Birthplace (State or Foreign
Funeral Director		Usual Residence of Decedent			Country) Unk
' any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Maryland 28a-f show d at once.	tor	MD Baltimore Dundalk	146	2- 0:4:£3464	1 Yes 2 No
136 hin 72 hours after death with the 1 than "matural", or items 23a or edieal Examiner must be notifie	al Director	10e. Street and Number  3128 Baybriar Road  21222		USA	
	by Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	Rican, etc.)	White, e	
	eted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  Unk  Lor Dates:  16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret	work done dired) Unk	16b. Kind of Busin	ess/Industry unk
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medical	Be Comple		e (First, Middle, M	I_ faiden Surname)	unk
MD 21 d 2 should th and Me n 27 is man	To	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or  0.C.M.E.  111 Penn Street Ba		MD 212	01
Baltimore, MD 2121 permit. Pages I and 2 should be fi Department of Health and Mental I Important: If tiem 21: in anxied injury or other traumatic event,		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other) Specify: in State	Date	20c. Location - Ci	ty or Town, State
Balt permit, Depart Import injury		21. Si natura of Fineral Service Licensee Ronald S. Wade, Firector State Anatomy Board Baltimore, MD 2120	d 655 W.	Baltimo	re Street
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate cause (Final disease a. Alcohol, Cocaine and Doxepin Intoxication				Approximate Interval Between Onset and Death
Lauminer		or condition resulting in death)  Due to (or as a consequence of):			
kecuted and - transit	aminer	Sequentially list conditions, if any, leading to immediate			
	I Exa	events resulting in death) Last Due to (or as a consequence or):  d.			
60, ate be exe hysician a	Medical	UNPENDED AMENDED			
Box 6876 death certificate he attending phy d for use as the b	Physician/Mo	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1			
O. Bo at the de d by the stached f		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tol	bacco use contribu	te to the cause of death?
S, P.O uires that t n signed b	ed by		1 Yes		Probably 4 Unknown
Record  The law req icate has bee	Completed		24a. Was a autops perform	sy prio med? dea	re autopsy findings available r to completion of cause of th? Yes 2 No
Division of Vital Records, P.O. Box 68760, within 24 hours and executed within 24 hours after death. To the Funcial or Attending Ebysician: The law requires that the death certificate be executed within 24 hours after death. To the Funcial of the Funcial after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	å	25. Was case referred to medical examiner?  1. Was 2. No.   Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other   Nursing Home 5   Residence 6 ✓ Other Scene			
	ation: To	27. Manner of Death  1 Natural 2 Accident  No  1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing 4 Nursing 2 Bab. Time of Injury FOUND: May 21, 2009  1 Yes 2 No  1 Yes 2 No		ow injury occurred	Striet. Scene
	Certification:	3 Suicide 6 Could not be determined Coperation Homicide Residue 1 Could not be determined Coperation Residue 1 Cop			
To the Hos within 24 h To the Fun completely	edical	29a. Certifier (Check only one)  2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
	Σ	29b. Signature and title of certifier  29c. License number  O.C.M.E.		29d. Date signed (Month, Day, Year) May 21, 2009	
		30. Name and address of person who completed cause of death (Item 23a)  Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2120	)1		
St Regis	ate trar	31. Date filed (Month, Day, Year)  32. Registrar's Signature			
DHMH 17 Rev 1/2	001	ORIGINAL			

amend #5 Per Ana Bd G895 10/01/09 JH
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 5:05AM **Physician** B1661NS 2007 MAY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE SUMMI BALT MORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb 6, 1929 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday **Funeral** Days Hours Min. Maryland 1 ☐ M 2 🗓 F 214-<del>26</del>-8307 80 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 ☐ No Director MDBaltimore Halethorpe 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 3300 Benson Avenue 21227 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2∑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2**X** No Specify: white Specify. ģ 3 ☐ Widowed 4 X Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) healthcare 12 clerical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph F. Brocato Mary D. DiPaola 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Marcella Biggins/daughter 14953 Cherrywood Drive Laurel, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4MDonation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Director 23a. Pat 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC BREAST CARCINOM **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical as the l attending | 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) ned by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown been si should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 No 1☐ Yes 2 No 1 ☐ Yes within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3□ DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide To the Hospital or 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 06/05/2009 M.O. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAMMONDS FERRY RD BALTIMORE, MD 21227 31. Date filed (Month, Day, Year) State JUN 1 1 2009 Registrar

DHMH 17 Rev 1/2001

			State of Maryland		tment of H <i>ificate of L</i>			F2 40 40	
			Registrar  1. Decedent's Name (First, Middle, Last)		TOUTO OF E	704177	2. Date of Death	J. No. 2	3. Time of Death
	Physici /Medio		Charles W. Bell				May 26,	2009 Yes	3:00 AM M
and of	Examin		4a. Facility Name (If not institution, give street and number)	4	b. City, Town, or	Location of Death		4c. County of D	
(		н	Heartland House Inc		Grasonv				Anne's
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last 1 № № 2 □ F 84		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, )		Birthplace (State or Foreign Country)
			Usual Residence of Decedent				Mar 23,	1925   Wa	shington DC
	rylane show	L	MD 0	own or Locat					10d. Inside City Limits
	8a-f s	Director		sonvil]					1 ☐ Yes 2 ☐ No
	with the		10e. Street and Number		10f. Zip Code		100	g. Citizen of What	Country?
	ns 23	Funeral	426 Oyster Cove Drive #2D  11. Marital Status   12. Was Decedent Ever in U.S.	13 Wa		1638	acify Yes or No.	USA 14 Bace A	merican Indian,
9	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Examinar must be motified at		Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No			spanic Origin? (Sp n, Mexican, Puerto	Rican, etc.)	Black, W	
93	ral", c	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 143-45	5   1	Yes 2√∏No	Specify:		Specify:W	nite
<u>5-</u> (	72 h "natu	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give kin	nt's Usual Occupa ad of work done d	uring most of worki	ing   16	b. Kind of Busine	ss/Industry
7	within ene. than	dmo	Elementary/Secondary (0-12) College (1-4or 5+)		NOT use retired) ttorney	_		1ega	1
g D	filed I Hygi other ent, t	Be Co	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, Ma		
<u>la</u> n	Aenta Aenta rked ric ev	To B	Charles Nelson Bell			Flore	ence M. H	ooper	
Mary	2 shound In and In		19a. Informant's Name/Relationship (Type. Print) The1ma Be11/spouse	19b. Mailing /	Address (Street a	nd Number or Rura ve Drive	#2D Gras	City or Town, Stat	e, Zip Code) MD 21638
e)	1 and Healt em 27			e of Disposition				c. Location - City	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinational by notified at once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (\$pecify)	etery, cremat	tory or other place	9) :		•	
Ball	permit Depart Import any Inj		21. Signature (Euneral Ser ce Licensee No. 11 S. Walt, Mirector	Sta	lame and Address te Anato	s of Facility my Board	655 W. B	altimore	Street
			23a. Part 1. Enter the disease, or complications that caused the death. Dishock, or heart failure. List only one cause on each line.	Do not enter t	the mode of dying	MD 2120	or respiratory arres	t,	Approximate Interval Between
in	Physician		Immediate lause (Final disease or condition						Onset and Death
- Land	/Medical		resulting in death)  a  Due to (or as a consequence	ce of):	,				
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	ne it	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ce of):					
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68760	ificate be executed g physician and is the burial-traneit	edical	d						
89	ertifice ing ph as th		IF FEMALE:						
Box	eath certifi attending   for use as	ian/l	23b. Was decedent pregnant in the past 12 months?   23c. If yes, outcome of pregnancy   1 □ Live birth   2 □ Fetal dea	ath 3 ☐ E	ctopic pregnancy			23d. Date of Month	delivery Day Year
o.	The law requires that the death cert ate has been signed by the attending bage 2 should be detached for use a	Physician/M	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown	n 5∐O	other (specify)			World	buy roan
J.	sician: The law requires that the de certificate has been signed by the rector, page 2 should be detached		Part II. Other significant conditions contributing to death but not resulting	g in the unde	erlying cause give	n in Part I.	23e. Did toba	cco use contribute	e to the cause of death?
rds	quires an sign uld be	ed by	Colen Co	nes			1 ☐ Yes	2 🗆 No 3 🗆	Probably 4 Unknown
ဝ၁	aw re as bee 2 sho	plet	R705 tal	3 60	verec.		24a. Was an	24b. Were	autopsy findings available
Vital Records,	The ate ha	Completed	round 10	000	Hay eles	and la face	autopsy performe 1 □ Yes 2 □	d2 death	to completion of cause of n? ∕es 2 ∐ No
ıta I	cian: ertific ector,	Be	25. Was case referred to medical examiner?	24642		26. Place of Death	(Check only one)		
5	Physical this call dire	e.	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/		3 □ DOA Othe	r: 4 🗆 Nursing Ho	me 5 Residence	ce 6 🗷 Other (S	nursing Becify) home
0	ding h. After fune	ertification:	1 ☑ Natural 5 ☐ Pending (Month, Day, Year)	b. Time of Injury	28c. Injury Work? M 1 🗆 Y	at ? res 2 □ No	28d. Describe how	injury occurred	
DIVISION	Atten r deal sctor; by the	ilica	3 Suicide 6 Could not be 28e. Place of Injury - At home.	, farm, street,					Rural Route Number,
5	tal or s after al Dire ed in l	Cert	4 ☐ Homicide determined building, etc. (Specify)				City or Town,	State)	
:	Io the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, p	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination and manner stated.	dge, death or and/or inves	ccurred at the tim stigation, in my op	e, date and place, inion, death occurr	and due to the cau red at the time, date	ise(s) and manne e and place, and	r as stated. due to the cause(s)
:	vithir To th	M	29b. Signature and title of certifier		29c. License			I. Date signed (Mo	
			Pott Greefell ao						
			30. Name and address of person who completed cause of death (Item 23: Roth Cheen field with 139 oll 5.	a) (Type, Prin	nt)	Rd	Mu-yolis	s. Ml	- 214d
	Stat Registra	e	31. Date filed (Month, Day, Year) 32. Registrar's Signature						

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	State of Maryland / Department of Health and Me 1 - State Registrar Certificate of Death	-	gierie Reg. No. 1	2000	10602
				2. Date of Dea		Vo	3. Time of Death
	Physicia		GEORGE A. BOOMER SR. J	Month	Day	Year 2009	6:00 P M
4.	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	ONE	4c. Co	ounty of Death	0.001
	LXamm	C1	4820 DEANWOOD DR. CLINTON		PRT	NCE GEO	RGE 'S
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birt (Month, Da	th		ace (State or Foreign
	Director		579-90-9896 1 M 2□ F 70 Yrs. Months Days Hours Min.	12/10/			CAROLINA
	р		Usual Residence of Decedent				
	rylan how	_	10a. State 10b. County 10c. City, Town or Location CLINTON			110	0d. Inside City Limits 1 Yes 2 No
	e Ma	5					
	or 28	Ji e	10e. Street and Number 10f. Zip Code		-	n of What Coun	
	th wi	Funeral Director	4820 DEANWOOD DR. 20743			D STATE	5
	ems ems	ne	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specific Process) If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No Rican, etc.)	- 14	<ul> <li>Race - America</li> <li>Black, White, e</li> </ul>	
98	afte or it		1 ☐ Never Married 2 ☐ Married 1 A Yes 2 ☐ No Specify:			pecify: BLA	CK
21215-0036	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ant, the Medical Evaminer must be multified at	d by					
7	"nat	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give hind of work done during most of working) (Give hind of work done during most of working)	g .	16D. KING	of Business/Inc	lustry
12	vithin	d m	Elementary/Secondary (0-12)  College (1-4or 5+)  FEDERAL POLICE OFFICE	ER	GOVE	RNMENT	
7	Hed v		17. Father's Name (First, Middle, Last)  18. Mother's Name		. Maiden Su	ırname)	
auc	ntal l ed ol	Be		OMER		ĺ	
Ë	d Me mark natic	은			or City or T	Town State Zin	Code)
Maryland	d 2 sl th an 7 is r traur				-		0000)
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altimore,	nt of nt of it it		12 Burial 2 ☐ Cremation 3 ☐ Removal from State MD VPPPBAN CEMETERY 6/10/0		CHELT	ENHAM,	MD.
ij	rtmer rtant rtant njury		4 Donation 5 Dotner (Specify)				
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Macrical Examination in the Invitilised at once.	, ,,	CAI	PITOL M			000
			The way fally 1425 MARYLAND AVE.,			D.C. 20	Approximate
			23a. Part1. Enter the disease, or complications that caused the death. Define the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	r respiratory a	urest,		Interval Between Onset and Death
1	Physician		Immediate Cause (Final disease or condition resulting in death)				HYMONTUS
2	/Medical Examiner		Due to (or as a of equence of):				
	_xammo	-	Sequentially list conditions, if any leading to immediate b.  Due to (or as a consequence of):				
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387	ficate phys s the	edical	d				
_	certif nding se as	₩.	IF FEMALE: 23c. If yes, outcome of pregnancy		23	d. Date of delive	erv
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Ř	ne law e has ge 2 s	mp		auto	psy ormed?	prior to co	mpletion of cause of
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of	Phy r this ral di	5	1 Inpatient 2 En/outpatient 3 DOA 4 Nursing Hor	me 51 Hesi 28d. Describe			y)
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<u></u>	deat deat ctor: y the	ica	3 Suicide 6 Could not be 389 Place of Injury . At home farm street factory office	28f. Location	(Street and	Number or Rura	al Route Number,
Division of Vital Records,	lor A after Direct	ertification: T	4 Homicide determined building, etc. (Specify)		wn, State)		
_	spita nours neral	O	29a. Certifier 1 2 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place,	and due to the	e cause(s) a	and manner as	stated.
	To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	edical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence) and manner stated.	ed at the time	, date and p	place, and due to	o the cause(s)
	To the within To the Somp	Me	29b. Signature and title of certifier 29c. License number		29d. Date	signed (Month,	Day, Year)
	->-0		My Shudhering M.D. DEZZOI		6	9100	7
	1	17/4	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		1	110	
1	11		Booins Andresmin 1221 Mercastile IN Lenn	er No	e bie	& NA	20774
	Sta	te	30. Name, and address of person who completed cause of death (Item 23a) (Type, Print)  Robin Andels and 1221 Mencantile Lu. Upper  31. Date filed (Month, Day, Year)  32. Redistrar's Signature  JUN 11 2009 Luna S. Januar	(3)		1 1 1	- 1
	Registr		IIIN 1 1 2009 Jenen S. Jak				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Dav Month **Physician** 7:40 A M June 11 2009 Elvira Celenza /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** s. Fagley Street Baltimore 306 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 ☐ M 2 🔀 F 216-30-9546 95 Argentina Director 6-15-1913 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1XYes 2□No Director Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number within 72 hours after death with 21224 306 S. Fagley Street U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☆ No If Yes, Give 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify. Specify: White þ 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, the Market is the market of the staumatic event, the Market is any Injury or other traumatic event, the Market is any Injury or other traumatic event, the Market is any Injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Haas Tailoring Seamstress 5th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Giuseppina Marchesi Caramanico Vincenzo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Anselmo Celenza - Son Fagley Street Baltimore, Md. 21
(Name of Date 20c. Location - City or Town, State 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 6-13-2009 Baltimore, Maryland 22. Name and Address of Facility Joseph N. Zannino Jr. F.H. 21. Signature of Funeral Service Licensee for an 263 S. Conkling Street Balto. Md. 21224 23a. Part1. Enter the dis as , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail re. List only one cause on each line. Immediate Cause (Fint) disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or any, if Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): requires that the death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 □ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed?

1 □ Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral dir Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 2 ☐ Accident 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: A completely filled in by the f 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

Hudsin

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

2801

32. Registrar's Signature

			For State Registrar	State of Maryland			f Health and M of Death		ene200	9 18684
	Physicia		1. Decedent's Name (First, Middle, Last)	1 0 1				2. Date of Death Month	Day Yes	3. Time of Death
`	/Medic			nalene Cole		# 02 T	al analism of Conth	June 9,	2009	7:00 P M
	Examin	er	4a. Facility Name (If not institution, give st Charles County Nu			LaP1	n, or Location of Death		Charles	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Ye	ear If Under 24 Hrs.	8. Date of Birth	9. 8	Birthplace (State or Foreign
	Director		232 70 7965	M 3√2 F 83	Yrs.	Months Da	ys Hours Min.	Dec 15,	1925 We	est Virginia
	pur *		Usual Residence of Decedent  10a. Slate 10b. County	10c. City.	Town or Loc	ation				10d. Inside City Limits
	Maryi febo	Į.		Uı		arlboro				1 □ Yes 2 XX
	the rouli	Director	Maryland Prince Ge 10e. Street and Number	orge		10f. Zip Cod	le	10	g. Citizen of What	Country?
	death with the Maryland me 23a or 28a-f ehow r must be rodified at		9613 Muirfiel	d Drive		1	20772		United St	tates
	r dea	Funerai	11. Marital Status	2. Was Decedent Ever in U.S Armed Forces?	6. 13. V	Vas Decedent Yes, specify (	of Hispanic Origin? (Sp Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)		merican Indian, /hite, etc.
2	rs afte	<b>by</b> Fi	1 Never Married 2 Married  3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:	1	□Yes 2₩	No Specify:		Specify:	White
3	2 hours		15. Decedent's Educa	ation	16a. Deced	ent's Usual Oc	cupation		6b. Kind of Busine	ss/Industry
2	thin 73	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	life. L	O NOT use re	one during most of work tired)	ing	0 11	
V	ed wit	Con	12	4	Home	maker			Own Ho	ome
2	be fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name (First, Middle, Last)  John Leroy Winto	n				e (First, Middle, M Saltsma		
Ž	hould d Mer marke matic	ဠ	19a, Informant's Name/Relationship (Typ		19h Mailin	a Address (Str	reet and Number or Rur			e. Zip Code)
<u>0</u>	th and 2 s		Ruth Ouellette (D	· '			ield Drive,	Upper M	arlboro.	MD 20772
ב ב	s 1 al		20a. Method of Disposition	20b. Pla	ace of Dispo:	sition (Name o	f	Date 2	0c. Location - City	or Town, Slate Virginia
	Pages nent of I ant: If its ary or o		1 🕅 Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)				tery June 1	5, 2009	Hunting	ton, West
מו	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene.  Brownstant: If them 27 is marked other than "natural; or Iteme 23a or 28a-f show eny injury or other traumatic event, it a Medical Examinar must be notified at once.		21. Signature of Funeral Service Micense	4						nc 6633 01d
	20 E ● a		23d. Part1. Enter the disease, or complic	1 mooas7			ia Ferry Ro			20735 Approximate
			shock, or heart failure. List only one	e cause on each line.						Interval Between Onset and Death
7	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence	otic C	asour	vasryly	disiss	<u></u>	
	Examiner									
-	ם יו	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	சாம் பி).					
	ecute and trans	Examin	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a consequ	ance of):					
0/00,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	alE		Due to (or as a consequ	61106 01).					
000	ficate g phys	edical	d.							
Š	n cert	D/M	IF FEMALE: 23b. Was decedent pregnant	ic. If yes, outcome of pregnar		Ectopic pregn	ancu		23d. Date of	
	w requires that the death certific been signed by the attending p should be detached for use as i	Physician/Me	in the past 12 months?	4☐Pregnant at time of de		Other (specif)			Month	Day Year
۲.	at the	Phy	9 ☐ Unknown  Part II. Other significant conditions cont		lting in the	adochioa onua	a guan in Part I	23a Did tob	acco use contribut	te to the cause of death?
oras,	signe signe	l by	Part II. Other significant conditions cont	induting to death but not lesu	iling in the ur	idenying cause	given in Fan i.			Probably 4 Unknown
5	w requ	etec						24a. Was ar	24h Were	a autopsy findings available
ב ב	sician: The law s certificate has b lirector, page 2 s	Completed						autopsy	ned? deat	
		0	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes 2 th (Check only one		res 2Larino
<u> </u>	nysici iis cer direct	To B	examiner?	ospital: 1   Inpatient 2   E	ER/Outpatien	t 3 DOA	Other		nce 6 Other (S	Specify)
0	Attending Physician: r death. ector: After this certific: by the funeral director,		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Injury al Work?	28d. Describe ho	w injury occurred	
VISION	ttendi death. tor: A	cati	2 Accident investigation 3 Suicide 6 Could not be	Co. Disea of lainer, At he			1 ☐ Yes 2 ☐ No	29f Location (St	reat and Number o	r Rural Route Number,
5	after after Direction by	Certification:	4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	nie, iaim, str	еөт, тастогу, оп	rice	City or Town		Trible Trodie Turnos,
1	To the Hospital or Attending Physician: Within 24 hours after death. To the Funerel Director After this certific completely filled in by the funeral director,	edical C	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	ician: To the best of my knower: On the basis of examination and manner stated.	wledge, death ion and/or in-	occurred at the	ne time, date and place, my opinion, death occur	and due to the ca	ause(s) and manne ate and place, and	r as stated. due to the cause(s)
J	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. Li	cense number	25	9d. Date signed (N	fonth, Day, Year)
	,- ,- ,- (		)			D	22574	MIS	6/16	1/09
			30. Name and address of person who con	mpleted cause of death (Item	23a) (Type,	Print)			100	1 1
			12070 Old Lin	re Cente	r St	e X	of Wal	dost.	Mid.	20603
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signat	Box					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 20a-c, per fh g892 6-18-09 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 12:10 AM 2009 Linda Lee Cosby UNE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) October 24,1942 9. Birthplace (State or Foreign Country)
New York 5. Social Security Number 218–40–4803 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2X F Months Director 66 Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County ns 23a or 28a-f show 1 ☐ Yes 2 X No Director Maryland Anne Arundel Arnold the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hyglene. ant: If Ifem 27 is marked other than "natural", or Items 23a or ant: If Ifem 27 is marked other than "natural", or Items 23a or ury or other traumatic event, I'm Actical Example mast be a 820 David Dr. 21012 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2X No Specify: à Specify: white 3 ☐ Widowed 4XX Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) consultant nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ James Reginald Cosby Vennie Underwood 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James R. Cosby/father 719 Maiden Choice Lane 21228 Catonsville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Pages
Department of
Important: If It
any injury or o Greenmount Crematory

Dulancy Valley Mem Card

June 15,2009 TMBurial 2 ☑ Cremation 3 ☐ Removal from State Baltimore 4 ☐ Donation 5 ☐ Other (Specify) -Timonium, Maryland 21. Signature of Funeral Service, Licensee John O. Mitchell IV, Funeral Services of Dulaney Valley 200 E. Padonia Rd. Timonium, MD 21093 P.A. John D. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CHRONIC OBSTRUCTIVE PULMONARY disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transi Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day signed by the a 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ EUMONIA 2 No 3 Probably 4 Unknown icate has been si , page 2 should t 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an ppital or Attending Physician: The ours after death.

eral Director: After this certificate filled in by the funeral director, pag 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ★ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 🗖 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours at To the Funeral D Hospital 29a. Certifier Medical 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mones 7531 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 204 Veterans State Registrar

kenneth Chamb		State of Maryland / 1- For State Registrar	Departme Certifica			Mental Hy		eg. No. 201	19 1868
Physici	an/	Decedent's Name (First, Middle,Last)	h				2. Date of Dea Month	th Day Year	3. Time of Death
Medical Exami	ner	Kenneth R. Chan  4a. Facility Name (if not institution, give street and number)	bers	T At	. City, Town, or Lo	ocation of Death	June 5, 20	4c. County of Deal	2201 hrs
		Franklin Square Hospital		1	Rosedale	oction of Bodan		Baltimore Co	
Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthe	day)	If Under 1 Year	If Under 24Hrs.	8. Date of Bir	th(MM/DD/YYYY) 9. Bi	
Director		232-32-8518   1XM 2_F	79	Yrs.	Months Days	Hours Min.	July 6		ountry) W
,		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town o	r Locatio	n				10d. Inside City Limits
d and an		MD Baltimore	Park						1 Yes 2 X No
Maryland 28a-f show any <u>1 at once.</u>	Director	10e. Street and Number	- 427	1	10f. Zip Code		1	0g. Citizen of What Co	untry?
with the Maryland ns 23a or 28a-f sho be notified at once.		3332 Acton Road			21234			U.S.A.	
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	Funeral	11. Marital Status  1 Never Married 2 Married Armed Forces?	Ever in U.S.		Decedent of Hispa s, specify Cuban, I			- 14. Race - Ame White, etc.	rican Indian, Black,
er deal		Never Married 2 Married 1 X Yes 2 3 Widowed 4 Divorced If Yes, Give Year	No		Yes 2 X No		,	Specify: Whit	te
urs aft tural" amine	d by	15. Decedent's Education (Specify only highest grade comp	oleted) 16a. D	ecedent'	s Usual Occupatio	n (Give kind of w		16b. Kind of Business	
36 hin 72 ho e. than "na dical Exa	lete	Elementary/Secondary (0-12) College (1-4 or 5	+)		st of working life. [ rici an	OO NOT use retire	ed)	Steel	
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	Completed	1 2		шес			/e:		
21215-0036 ould be filed within 7 I Mental Hygiene. s marked other than it event, the Medica	Be C	Charles Chambers			18	Lillian C	,	Maiden Surname)	
	70 E	19a. Informant's Name/Relationship (Type, Print )		_	,	and Number or R	ural Route Nur	nber, City or Town, Star	te, Zip Code)
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic er		Mark Chambers/ SON						e, MD 21666	
Baltimore, permit. Pages I a Department of He Important: If ite		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State			on (Name of ceme splace) Memor		Date	20c. Location - City o	
Itim it. Pag irtment ortant:		4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee	Gar	dens		00/12	-	Timenium, M	·····
Ba Perm Depa Impa		MICHILIA & ICIN	$\bigcirc$	15 Vi	ns Funera O Harford	l Chapel & Rd. Parkvi	Crematic Lile, MD	n Services 21234	
Physician	7	23a. Part I. Enter the disease, or complications that caused t failure. List only one cause on each line.	he death. Do not						Approximate Interval Between Onset and
/Medical xaminer	4	Immediate Cause (Final disease a. Atherosclerotic C		ar Dise	ase				Death
		- Date to (or as a consen	quence of):						
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	quence of):						
ansit	Examiner	(Disease or injury that initiated events resulting in death) Last	quence of):						
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O, e be ex ysician burial	Medical	UNPENDED AMENDED						1=1=	
876 rtificat ing ph		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcom	e of pregnancy	Feta	l death 3	Ectopic pregnar	ncy	23d. Date of delive Month	Day Year
Box 6876  The death certificate  The attending phy  The attending and the for use as the lead for use as t	· 20	Yes 2 No 9 Unknown 9 Unknown	ime of death 5	Oth	er (Specify)				
D. B t the d by the	Phy	Part II. Other significant conditions contributing to death	but not resulting	in the un	derlying cause giv	en in Part I.	23e. Did to	obacco use contribute t	o the cause of death?
P.C.	d by						1 Ye	s 2 🗸 No 3 Pr	obably 4 Unknown
ords	ompleted						24a. Was		autopsy findings available ocompletion of cause of
of Vital Records, g Physician: The law requir the this certificate has been si neral director, page 2 should b	mo						perfo	rmed? death?	
Vital Rec ysician: The l his certificate l director, page	Be C	25. Was case referred to medical examiner? Hospital: 1 Innation				of Death (Check o			
Physical this	ပ	1 ✓ Yes 2 No	t 2 🗹 ER/Out	tpatient ime of Inj				Residence 6 Oth	er:
on C ath. rr: Afi	tion	1 ✓ Natural 5 Pending (Month, Day, Ye	ar)			s 2 No		non nyany cocamea	
Division at or Attendiurs after death.  at Director: A led in by the fu	ifica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Inju	ury - At home, fan	m, street	, factory, office bui	ilding, etc.	28f. Location ( or Town, S		Rural Route Number, City
Div spital or nours afte neral Dii	Certification:	4 Homicide determined (Specify)					OI TOWIT, C	olale)	
Division of Vital Records, P.O. Box 68760, To the Itospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral direction, page 2 should be detached for use as the burial - transit	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my Medical Examiner; In the basis of exam							
To wit	Mec	29b. Signature and title of certifier			29c. License			29d. Date signed (M	
0/					O.C.M	i.E.		June 6, 2009	
OCME		30. Name and address of person who completed cause of de		111	Donn Street	Poltimore Ad	D 24204	.t	
	ate	Mary G. Ripple MD. Deputy Chief Medic  31. Date filed (Month, Day, Year)  22. Registrar			Penn Street,	pailimore, M	U Z 1201		
Regist		JUN 1 1 2009 Server	B. A	ark					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1055 AM NUT Pyung Yi Choi 08 2009 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) HOSPITAL AGNES Baltimore SAINT If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Seoul, Korea 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 1 □ M 2 🖾 F Yrs Nov. 29, 1926 82 213-08-0148 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21212 United States 5220 York Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 No Specify Specify: Korean 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ann Lim Dol Bin Lim 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40 Winterberry Court Cockeysville, MD. Mr. Dae In Choi (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State June, 10, Dulaney Valley Mem. 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland 22. Name and Address of Facility neral Service Licensee 21. Signatu Peaceful Alternatives Funeral&Cremation Ctr., P.A. 21093 Timonium, Maryland 2325 York Road Pay 11 Enter the disease or com shook, or heart failure. Jist only r the disease or complications the Approximate Interval Between Onset and Death caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on Immediate Callse Final cholecys days disease or condition resulting in death) te fai lure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Pneumonio resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 □Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 □ Yes 2 🗆 No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how injury occurred

/Medical Examiner 68760 ۵ Box Ö σ. Records, Vital o Division

attending physician and for use as the burial-transit ed by the a signed t been certificate has be rector, page 2 sl Physician: this After thi or Attending death. neral Director; after 24 hours a Hospital

**Physician** 

/Medical

Examiner

10a. State

Director

Funeral

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Completed

Be

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Examine

**Funeral** 

Director

r than "natural", or items 23a or 28a-f shov

marked other than

12 should be fine the should be the should be 
1 and 2 s Health ar

other t

item

permit. Pages 1 Department of H Important: If ite any injury or ot

**Physician** 

hours after

within 72 h

Baltimore, Maryland 21215-0036

Physician/Medical 2 Completed Be မှ Certification:

Medical

State Registrar 29a. Certifier

(Check only

27. Manner of Death 5 Pending investigation 1 X Natural 2 Accident

29b. Signature and title of certifie

6 ☐ Could not be 3 Suicide 4 Homicide

28a. Date of Injury (Month, Day, Year)

Injury at Work? 1 ☐ Yes 2 ☐ No

1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

MD

29c. License number P. 20655 29d. Date signed (Month, Day, Year) JUN 08 2009

MD

21229

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

doo caton Ave Battimore VALI KHANI MOHAMMAD

31. Date filed (Month, Day, Year)

JUN 1 1 2009 . Registrar's Signafire

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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Edward Clayton 10:35 AM **Physician** 2009 June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford County **Examiner** Jarrettsville 3902 Emrick Lane If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday) Sex XXM 2□ F **Funeral** Days Hours Min. July 17, 68 214-36-8542 Kingsville, MD Director Usual Residence of Decedent 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Wedical Expedient or an utilized at Jarrettsville Maryland Harford County 1 ☐ Yes 2 X No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3902 Emrick Lane 21084 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) within permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'amy injury or other traumatic event, the Meance. Elementary/Secondary (0-12) MIA College (1-4or 5+) Diesel Mechanic N/A 12 17. Eather's Name (Eirst, Middle, Last Edward Clayton 18. Mother's Name (First, Middle, Maiden Surname) Be Alice Schmidt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Nancy Clayton (Wife) 3902 Emrick Lane, Jarrettsville, Maryland 21084 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Forest Hill, Maryland June 8, 2009 Evans Funeral Chapel 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services — Bel Air
3 Newport Drive, Forest Hill, Maryland 21050 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Kidney month /Medical Due to (or as a con equence of): Examiner months auto immun Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): the death certificate be executed as the burial-tran that initiated events resulting in death) Last P.O. Box 68760€ Due to (or as a consequence of): physician Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for Year Month Day 5 Other (specify) ☐Yes 2☐No detached the 9 Unknown 9 Unknown signed by t d be detach Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۾ 1 🔲 Yes 2 No 3 Probably 4 Unknown page 2 should Completed was a autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an certificate 1 ☐ Yes : After this certification, page 1 Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2**√**√No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Aesidence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Injury 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Hospital 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Narrisville Rd 31. Date filed (Mor. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 11:45 PM DAVID DEBARSY DE GIVE JUNE 2009 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMEN NATIONAL INSTITUTES OF HEALTH BETHESDA If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday, **Funeral** Days 1⊠ M 2□ F 134-34-8988 66 Director Jan. 17, 1943 New York Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a.4 ehrer eny injury or other traumetic event, the Mental Industrial Control of the Department of the D 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director VA Fauguier Delaplane 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20144 USA Completed by Funeral 1402 Winchester Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 ☐ No 1 Never Married 2 X Married If Yes, Give Year or Dates: Unk 1 ☐Yes 2 XNo Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College\_(1-4or 5+) 5+ Banker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Paul de Barsy de Give Eleanor Hoquet Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Winchester Road plane, Virginia 1402 Winch Delaplane, 20144 Josephine Fisher de Give-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 DOther (Specify) Metropolitan Crematory 6-9-09 Alexandria, Virginia 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Royston Funeral Home Me 102 E. Washington St., Middleburg, VA 23a. P. 11. Einer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ORGANIZING WEEKS CRYPTOGENIC /Medical Due to (or as a consequence of) Examiner YEARS SYNDROME MYELODYSPLASTIC Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 □ No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 063242 JUNE 07, 2009 NIRAV G. SHAH, MO no address of person who completed cause of death (Item 23a) (Type, Print) (3 20-145 BUILDING BETHETON, 10 CENTER DRIVE 20892 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Division of Vital Records, P.O.

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2 hour	GIE	ted		15. Decedent's	Education	<b>'</b> 58–6	16a. Dece	dent's Usual Occu			16b. I	Kind of Business	s/Industry un
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				ressler/	(Type. Print) spouse		19b. Maili 328	ng Address <i>(Street</i> Southern	and Number of Hill Di	r Rural Route No rive Ari	101d,	MD 210	12
<b>Baltimore</b> , permit. Pages 1 an Department of Heal Important: If item 2	ury or oth				☐ Removal from State	com	ce of Dispo netery, crei	osition (Name of matory or other pla	ce)	Date	20c. l	ocation - City o	r Town, State
permit. Depart	any Inj once.		21. Signature of Fi	uperal Service Lic Onald 5	wade, Dir	ector	-	2. Name and Addre ate Anat ltimore,	-		W. Ba	ltimore	Street
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VII /slclar s certi	lirecto	o Be	25. Was case referexaminer? 1 ☐ Yes 2 ☑	,	Hospital:	ent 2 EF	2/Outpatio	ott	OF:	Death (Check or		6 ☐ Other (Sp	
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DIVIS all or Atte s after des	d in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	28e. Place of in	ury - At home c. (Specify)	e, farm, str	eet, factory, office			on (Street a Town, Sta		Rural Route Number,
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Vithir To th	comp	M	29b. Signature and	title of certifier				29c, Licens	se number		29d. D	ate signed (Mor	oth, Day, Year)
		-	PN	sny	· ms			D5	753,	/	Ju	10 04	2004
			30. Name and addi	ress of person wh	o completed cause of c	death (Item 2	3a) (Type.	Print)	5 20	y m	ukr.	Julle	mo 2110+
Re	Stat egistra	-	31. Date filed (Mon	oth, Day, Year)	82. Registr	rar's Signatur	bar	es .					ith, Day, Year)  2009  MD 21108
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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death June 8. 2009 2:58 a M Dougherty Nancy L. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 17, 1928 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Maryland 217-26-5661 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 No Harford MD Baldwin 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21013 U.S.A. 2810 Glen Elyn Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify: White 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dorsey McCracken Emma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2810 Glen Elyn Way, Baldwin, MD C. Michael Dougherty-son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 06/12/09 Dulaney Valley Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Cicensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Acute Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death e contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No ☐Other (Specify) occurred

Division or Vital Records, P.O. Box 68760, burial-transit

Exami Physician/Medical Be Completed by Certification: To

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

Director

Funeral

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th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, It at Medical Evantinar must be notified at

Department of Health a Important: If item 27 is any injury or other trains

Physician

/Medical

Examiner

Pages 1

injury or other

Saltimore, Maryland 21215-0036

Atter this certificate has been s funeral director, page 2 should i To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After filled in by the completely

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25. Was case referred t	to medical							26.	Place of Dea	ath (C	Check only one)			
examiner? 1∐Yes 2∭ZNo		Hospital:	Inpatient	2 🗆 1	ER/Outpatient	3 🗆 1	DOA	Other: 4	I ☐ Nursing H	Home	5 ☐ Residence 6	G □Other (Spe	cify)	
27. Manner of Death 1   Natural 5 2  Accident	☐ Pending investigation	(1	ate of Injury Month, Day, Ye		28b. Time of Injury	М	1	njury at Nork? 1 □Yes	2 □No	280	d. Describe how injury	occurred		
3 Suicide 6 4 Homicide	Could not be determined	128e.P	lace of Injury - uilding, etc. (S	At hos	me, farm, street	t, facto	ory, offi	ce		28f	Location (Street and City or Town, State		ıral Rou	te Number,

29b. Signature and title of certifier

29a. Certifier

(Check only

MD

29c. License number D0068014

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 06/08/09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. HU & 500 Upper Chesapake Dr. Bel Air, MO 21014 31. Date filed (Month, Day, Year)

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. ( 2. Date of Death 1. Decedent's Name First, Middle, Last) Year O9 Day Month **Physician** Vans 12:07AM /Medical 4a. Facility Name (If not institution, give street and number) County of Death City, Town, or Location of Death Examiner Raltmore Himore mantan Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) Months Days 1 □ M 2 □ F Hours Director 17/1981 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location show Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Even in a trait by retitled and once. 1 kgs 2 No Director 10g. Citizen of What Country? 10e. Street and Number Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3 Widowed 4 Divorced altimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. <u>م</u> Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 200 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elbas 2 19b. Mailing Address (Street and Number or Rural Rout, Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition . Method of Disposition

1 ☐ Burial 2 Cremation 3 ☐ F

4 ☐ Denation 5 ☐ Other (\$pecify) 3 Removal from State 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death the mode of dving, such as cardiac or respiratory arrest. Immediate Cause (Final erebral **Physician** omoxi disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been sinned by the Advantage Lead. burial-tran Due to (or as a conse wince of): P.O. Box 68760, signed by the attending physician be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ≥ 2 No 3 Probably 4 Unknown cate has been si, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☒No 24a. Was an autopsy 2 No hugerten 1 Yes Division of Vital funeral director, 25. Was ca ferred to medical examiner: Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital of within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and tive of certifier

State Registrar

31. Date filed (Month, Day, Year,

30. Name and address of person who completed

32. Registrar's Signature

JUN 11 A. ford Raven Blvd, Baltimore,

ause of death (Item 23a) (Type, Print)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2009<sup>Year</sup> Norman Allen Emmons June 8, 11:40a™ 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Springvale Nursing Home Silver Spring If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 1/07/16/1922 Social Security Number 7. Age (In yrs. last birthday) 049-22-2248 86 Days Hours Min. 1 XX M 2 □ F Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State MD Silver Spring Montgomery 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8505 Springvale Road 20910 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No1 041 45 If Yes, Give Air Force Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 □ Yes 2 🛣 No Specify. Specify: 3 ☐ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) $\overset{\text{Elementary/Secondary (0-12)}}{12}$ College (1-4or 5+) Architect Architecture 18. Mother's Name (First, Middle, Maiden Surname) Grace Alice Baldwin 17. Father's Name (First, Middle, Last) Eude11 Emmons Norman 19a. Informant's Name/Relationship (Type. Print) Sandra Zamaria / POA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1300 Spring Street, 4th. Floor, Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Ardent Crematory 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 6/9/2009 Hanover, MD 4 Donation 5 Other (Specify) Mary land Cremation Services PO Box 1413, baltimore, MD 21203 21. Signature of Funeral Service/Licensee Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Multiple Myeloma disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear ☐ Pregnant at time of death 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Anemia 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an Altzheimer's Disease autopsy performed? Yes 2.22 No 2 □No 1 ☐ Yes 26. Place of Death (Check only one)

**Physician** / /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

Director

Funeral

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Completed

Be

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Examine

Physician/Medical

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Certification: To

Medical

3 Suicide

29a. Certifier

4 Homicide

(Check only

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the The Text after must be purified an once.

Maryland 21215-0036

altimore,

P.O. Box 68760.

Division of Vital Records,

sician and burial-transit law requires that the death certificate be executed attending physician for use as the buria led by the a signed by 1 d be detach icate has been si , page 2 should b The this certificate director, funeral c ne Hospital or Attending P n 24 hours after death. e Funeral Director: After t After by the filled in

25. Was case referred to medical examiner?

1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident

and manner stated

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

6 □Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) LX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

29b. Signature and title of certifier

D 36552

29c. License number

29d. Date signed (Month, Day, Year) June 9, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Pankaj Talwar, MD, 50 West Edmonston Drive, Suite 401, Rockville ,MD 20852

State Registrar

within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar		C	ertificate of	Death		Reg. No.	2009	18695
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	Examin	er		land Hospital		Clint	or Location of Deal	ın		County of Death Ince Geo	rge's
	Funeral Director		5. Social Security Number 228–38–3105	404 005	(In yrs. last birthd	Months Days					lace (State or Foreign
	and w		Usual Residence of Decedent  10a. State 10b. County	v	10c. City, Town or	r Location				10	0d. Inside City Limits
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	or 28s	Oirec	10e. Street and Number		серпень	10f. Zip Code			10g. Citize	en of What Coun	try?
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Balt	permit. Pages Department of Important: If i any injury or o		21. Signature of Funeral Service			22. Name and Addre	)	chael R.	Phe	lps & As	
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	2		30. Name and address of person VIJAY SHRI KA	who completed cause of dea		De, Print) RATIS RI	D. CLI	NOW_	MD.	20739	5
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		. For	Please	State of Ma			artment of h				•	
	_	<ul><li>State</li><li>Registrar</li></ul>				Ce	rtificate of	Death		Reg. No	2009	18696
Physicia: /Medica		1. Decedent's Name Helen	e (First, Middle, La T. Full						2. Date of De	ath Day	y Year 2009	3. Time of Death 08. 45 A M
Examine				ve street and number)			4b. City, Town, o	r Location of Dea	th		County of Dea	th
		Caton M	anor Nur	sing Home			Catonsv			В	altimor	e
Funeral Director		5. Social Security No. 217-16-0	937	Sex 7. Age 1 □ M 2 🔀 F	e (In yrs. i	last birthday) 6 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th ly, <i>Year)</i> 3 <b>,</b> 1	9. Bir 922 Po	thplace (State or Foreign ountry) land
pud M	-	Usual Residence of 10a. State	Decedent 10b. County		10c Cit	y, Town or Lo	ocation					10d. Inside City Limits
f sho	ō		,									1 ☐ Yes 2 🖾 No
the N 28a- notifi	Director	Maryland   10e. Street and Num	Frederi	ck	Mi	t. Air	10f. Zip Code			10a. Cit	tizen of What Co	ountry?
3a or		14005	Silver	Fern Drive			21771			US	Δ	ŕ
death	Funeral	11. Marital Status	DIIVEL	12. Was Decedent B	Ever in U.	S. 13.	Was Decedent of H	lispanic Origin? (	Specify Yes or No		14. Race - Am	
irs after	2	1 ☐ Never Marri	ed 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	No		1 ☐ Yes 2 ☑ No	Specify:	nto Rican, etc.)		Black, White	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed		15. Decedent's E ify only highest gr	ade completed)	- 1	16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	pation during most of wo	orking	16b. K	ind of Business	/Industry
withi jene. r thar	Ë	Elementary/Secon	ndary (0-12)	College (1-4or 5	+)		e Maker	-/			Own Hom	e
i filed I Hyg other	Be C	17. Father's Name (	(First, Middle, Las	t)		11011		18. Mother's Na	me (First, Middle,			
Alenta rked tic ev	90	John K	rajewski					Adol:	fina Marc	cini	ak	
shou and N s ma	- 115	19a. Informant's Na	ame/Relationship	(Type. Print)		19b. Maili	ng Address (Street	and Number or F	Rural Route Numb	er, City o	or Town, State,	Zip Code)
and 2 ealth n 27 i		Robina B	rough	Daughte	r	1400	5 Silver	Fern Dr	ive; Mt.	Air	y, MD 2	1771
of H		20a. Method of Disp		☐ Removal from State	20b. P	lace of Disperent	osition (Name of matory or other plac	ce)	Date	20c. Lo	ocation - City or	Town, State
ment ment ant:		4 ☐ Donation	5 ☐ Other (Spee	<del>%</del> \	At1		Cremator					e, Maryland
ermit epart nport ny in		21. Signature of Fu	peral Service Lice	nse	//	F F	2. Name and Addre	ess of Facility Stome of Ca	terling A	Asht le.	on Schw Inc.	ab Witzke
σ□ = α <b>ο</b> ι			Lan	ellts		0 1	630 Edmor	ndson Ave	enue; Ca	tons	ville,	MD 21228
		shock, or hea	rt failure. List only	nplications that caused one cause on each lir	ie.				ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause ( disease or condition resulting in death)	Final n	a	FA	ILVRÉ	TO THRI	vė				FEW DAYS
Examiner		, , , , , , , , , , , , , , , , , , , ,	- (	Due to (or as	a consequ	uence of):						
*	ē	Sequentially list cor	nditions, mediate	b. Due to (or as	a consequ	uence of):						
d ansit	Examiner	Sequentially list cor if any, leading to im- cause. Enter Under Cause (Disease or that initiated events	rlying injury									
an arrial-tr		that initiated events resulting in death) L	ast	Due to (or as	a consequ	uence of):						
ate be	<u>g</u>			<b>⊆</b> d								
ertifica ing ph	Med	IF FEMALE:										
To the Hospital or Attending Physician: The law requires that the death certificate be exeruted within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi	23b. Was decedent in the past 12 1 Yes 2 Unknown	months?	23c. If yes, outcome 1  Live birth 4  Pregnant at 9  Unknown	2 Feta	death 3	☐ Ectopic pregnand ☐ Other (specify)	су			23d. Date of de Month	elivery Day Year
that ned b deta				contributing to death bu						obacco	use contribute t	o the cause of death?
quires an sign	og p	DEE	NENOVS	THROMBISIS.	C.	OLITI.	s, Atria	/ Fibrallet	1 🗆	Yes 2	Ø(No 3□ F	robably 4 Unknown
aw rec	Completed		CONGE	STIVE HE	ACT	FIALL	RE, AN.	ENIA	24a. Was			utopsy findings available
The k te ha age 2	E O								auto perfo 1 □ Yes	rmed?	death?	completion of cause of s 2 □No
ian: rtiffica tor, p	D P	25. Was case refer	red to medical					26. Place of De	ath (Check only o		) ILITE	\$ 2 1110
nysic direc		examiner? 1 ☐ Yes 2 🍒	No	Hospital: 1 ☐ Inpatie	ent 2 🗆	ER/Outpatie	nt 3 DOA Oth	ner: 4 Nursing	Home 5 ☐ Resi	dence	6 ☐Other (Sp.	ecify)
ng Pł	Ë.	27. Manner of Death	h 5 🗆 Pending	28a. Date of Inju (Month, Day		28b. Time o Injury	of 28c. Inju		28d. Describe			
tendi eath. tor: A	Cat	2 ☐ Accident 3 ☐ Suicide	investigation 6 □ Could not I					Yes 2□No				
al or At	Certification: 10	4 ☐ Homicide	determined		ury - At ho c. <i>(Specif</i>	ome, farm, st	reet, factory, office		28f. Location ( City or To	Street ar wn, State	nd Number or F e)	Bural Route Number,
ne Hospit n 24 hour ne Funera	Medical	29a. Certifier (Check only one)		hysician: To the best of miner: On the basis of and manner sta	f examina							
To the vithing complete the com	Ž	29b. Signature and	title of certifie			-	29c, Licens	se number			ate signed (Mon	
			Mile	MO			Des	62634		Ju	NE 9, 2	.0= 4
			ess of person who	completed cause of d				R106.F	RD	COLU	M31d	Mg 2/144
State	е	31. Date filed (Mon									,	

		For	State of Maryland / De	partment of Health and I	Mental Hygi	ene
		1 - State Registrar	С	ertificate of Death	Reg	g. No. 2009   869
Physicia	an	1. Decedent's Name (First, Middle, Last)			Date of Death     Month	Day Year 3. Time of Death
/Medic		Robyn D.		T	June	8 2009 6.48AM
Examin	er	4a. Facility Name (If not institution, give s	·	4b. City, Town, or Location of Death		4c. County of Death
Funeval	-	Baltimore Washingto  5. Social Security Number 6. Sex		Glen Burni		Anne Arundel  9. Birthplace (State or Foreign
Funeral Director			M 2 <b>X</b> F 55 Yrs.	Months Days Hours Min	8. Date of Birth (Month, Day, 1	Year) Country) 53 Maryland
D		Usual Residence of Decedent			111 12 12	
arylar show	ř	10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
he Ma	Director	MD Anne Aru	ındel	Severn		
with t	Ģ	10e. Street and Number		10f. Zip Code	109	g. Citizen of What Country?
eath rs 23	Funeral	1724 Severn Tree		21144 3 Was Decedent of Hispanic Origin? (S	necify Ves or No.	United States  14. Race - American Indian,
fter d	Fun	1 Never Married 2 X Married	1 ∐Yes 2 🛣 No	<ol> <li>Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert</li> </ol>	o Rican, etc.)	Black, White, etc.
urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2X No Specify:		Specify: Black
72 hc	Completed	15. Decedent's Educ (Specify only highest grade	ation 16a. De	cedent's Usual Occupation ve kind of work done during most of work	kina 16	6b. Kind of Business/Industry
Agn."	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)	e. DO NOT use retired)	9	0 11
Hygie		17. Father's Name (First, Middle, Last)	<u> </u>	Home Maker	ne (First, Middle, Ma	Own Home
d be fantall sed of	Be C		<i>‡</i> 11	" " _ "	_	,
should be filed within 72 hours after death with the Maryland should be filed within 72 hours after death with the Maryland and Mental Hygiene. I show a marked other than "natural", or items 23a or 28a-f show umatic event, the Maddenl Evaniting must be notified at	은	Robert Hemph  19a. Informant's Name/Relationship (Typ.		ailing Address (Street and Number or Ru	anny Germa	
parmit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentall Hygiene.  Department of Health and Mentall Hygiene.  Department of Health and Mentall Hygiene.  And Injury or other traumatic event, the Mardian Evanting must be neithed at once.		Steven M. Fitzgera	·	4 Severn Tree Cour		
s 1 au of Hei		20a. Method of Disposition	20b. Place of Dis	sposition (Name of rematory or other place)		Oc. Location - City or Town, State
Page nent c		1 ☐ Burial 2 🖾 Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	del Crematory 06-	10-2009	Odenton, Maryland
permit. Departit Importa any Inju		21. Signature of Funeral Service L. ense		22. Name and Address of Facility Donaldson Funer		
3 82 E 8 8	7. 18	Alla	Mugeis	1411 Annapolis	Road Oden	ton, Maryland 21113
		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death. Do not e e cause on each line.	enter the mode of dying, such as cardiac	or respiratory arres	Interval Between
Physician		Immediate Cause (Final disease or condition	CONGESTIV	E HEART FI	AILURE	Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a consequence of):			
	<u>.</u>	Sequentially list conditions,	Due to (or as a consequence of):	RECURGITAT	LION.	12000100
rted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	bue to (or as a consequence or).			
be executed sloian and burial-transit	Exal	that initiated events c. resulting in death) Last	Due to (or as a consequence of):			
F E E	ical	L <sub>d</sub>				
3 %						
eath certific attending p for use as	Physician/Med	23b. was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 ☐ Ectopic pregnancy		23d. Date of delivery
ed fo	sicia	in the past 12 months? 1 ☐ Yes 2 M No		5 Other (specify)		Month Day Year
that the de led by the detached	Phy	9 Unknowń			00- Bid t-b-	acco use contribute to the cause of death?
ires the signed to be d	þ	Part II. Other significant conditions con  HYPERTENT(		e underlying cause given in Part I.		s 2 X No 3 Probably 4 Unknown
w requir	eted	TI/I DIVICINITY	7 1 1	-		
e law has b	Completed				24a. Was an autopsy performe	
sician: The l certificate ha		05.11			1 □ Yes 2	⊠No 1 □ Yes 2√2 No
Physician: this certific al director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital:	Othor	th (Check only one)	
ding Phy h. After this funeral d	$\vdash$	27. Manner of Death	1 ☐ Inpatient 2 ☑ ER/Outpa 28a. Date of Injury 28b. Time	e of 28c. Injury at	ome 5 Residen	nce 6 Other (Specify)
Attending or death. ector: After by the funer	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year) Injur	y Work? M 1 ☐ Yes 2 ☐ No		
Atte ectol by th	iii	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	eet and Number or Rural Route Number,
ital or rs after al Dir	Certification:					· · · · · · · · · · · · · · · · · · ·
To the Hospital or Attendini within 24 hours allocated death.  To the Funeral Director: Aft completely filled in by the fun	edical	(Check only 2 Medical Examin	ician: To the best of my knowledge, deer: On the basis of examination and/o	eath occurred at the time, date and place rinvestigation, in my opinion, death occurrences	e, and due to the cau	use(s) and manner as stated. te and place, and due to the cause(s)
the Ithe Ithe Ithe Ithe Ithe Ithe Ithe I	Medi	one)	and manner stated.			
<b>5</b> with <b>5</b> 00 00 00 00 00 00 00 00 00 00 00 00 00	2	29b. Signature and title of certifier		29c. License number  D 51596		d. Date signed (Month, Day, Year)
		1 dul	WY 1	0 3/376		Tune 8, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

K-Ambo (avavar 7845 Oakwood Road) Glen Burnie MD21061 31. Date filed (Month, Day, Year) State 32. Registrar's Signature JUN 1 1 2009

Registrar

				State of Marylan	3d /   10n/	artment of L	Joalth ar	d Mental F	lygion	Δ	
			For State	State of Marylar		rtificate of I		iu Meniai i			10000
			Registrar  1. Decedent's Name (First, Middle, Las	-t)		incate or i	Deam	2. Date of	Reg. No	2009	3. Time of Death
	Physicia /Medic		Dorothy Fran					Month 06	Da 0		
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	r Location of D	Death	40	c. County of Deat	h
			Seasons Hospice				dallsto		FD1 11		imore
П	Funeral		5. Social Security Number 6. So	ex 7. Age (In yrs	last birthday) Yrs.	If Under 1 Year Months Days		Min. 8. Date of (Month,	Birth Day, Year	9. Birt	hplace (State or Foreign buntry)
	Director		354-20-1494 Usual Residence of Decedent	01				09/14	4/192	/	IL
	yland Now		10a. State 10b. County	10c. C	ity, Town or Lo	cation				_	10d. Inside City Limits
	a-fs	ctor	MD Anne A:	rundel		Glen I	Burnie				1 ☐ Yes 2X No
	th the	Director	10e. Street and Number			10f. Zip Code			10g. C	itizen of What Co	ountry?
	23a ust b	ral	132 Shelley Road	d			21061				U.S.A.
	er dez	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origir an, Mexican, P	n? (Specify Yes or Puerto Rican, etc.)	No-	<ol> <li>Race - Ame Black, White</li> </ol>	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examination relation and itself at	by F	1 ☐ Never Married 2 ☐ Married 3 【 Widowed 4 ☐ Divorced	1		1∐Yes 2 <b>XXX</b> No	Specify:			Specify:	White
9	2 hou	ted	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occup	oation		16b. l	Kind of Business/	
21215-0036	hin 7: e. an "n	Completed	(Specify only highest grades) Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of d)	t working			
2	d wit	Son	10			Own	ner				stribution_
nd	be file	Be	17. Father's Name (First, Middle, Last)					Name (First, Mid		n Surname)	
Х	should I and Men s marke umatic	ပ္	Fey Kent					na Cummi	_		
Mar	12 sh h and 7 is rr traun		19a. Informant's Name/Relationship (7	. •		ng Address (Street					
e,	s 1 and 2 soft Health a litem 27 is		Mrs. Gloria J. Ht 20a. Method of Disposition			Shelly Ro		Glen Bur		Mary Lan	
Baltimore, Maryland	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		1 ☐ Burial 2 XX remation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	nemoval from State		osition (Name of matory or other place Cremator	1	5/11/2009	) c1	lan Rurn	ie, Maryland
≢	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licen			2. Name and Addre					Burnie, MD
ä	permi Depa Impo any ir once.		1milav		01357 S				-		
		_				THETECOH	runera	ir a crem	ia c TOI	T PELATC	CD
			23a. Part 1. Enter the disease, or comp							1 Servic	Approximate Interval Between
	Physician		23a. Part 1. Enter the disease, or comp shock, of heart failure. List only of Immediate Cause (Final disease or condition	olications that caused the dea one cause on each line.	th. Do not en	ter the mode of dyir	ng, such as ca	ardiac or respirato	ry arrest,	i servic	Approximate
	/Medical				th. Do not en		ng, such as ca	ardiac or respirato	ry arrest,	r servic	Approximate Interval Between
		L	Immediate Cause (Final disease or condition resulting in death)	one cause that caused the dead one cause on each line.  Atherosclere  Due to (or as a consection)	th. Do not ent	ter the mode of dyir	ng, such as ca	ardiac or respirato	ry arrest,	r servic	Approximate Interval Between
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O. Box 68	/Medical Examiner /sician and spring-transit	g	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, it any, leading to humaniate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 moorhs?  1	b.  Due to (or as a consect of the c	th. Do not enter the control of the	ter the mode of dying the control of	ng, such as ca	ardiac or respirato	ry arrest,	23d. Date of de Month	Approximate Interval Between Onset and Death  livery Day Year
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P.O. Box 68	/Medical Examiner /sician and spring-transit	Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, it any hauling to humaniate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 mooths? 1	b.  Due to (or as a consect of the deadless)	quence of):	Ectopic pregnance Other (specify)	ey ven in Part I.	23e. [ 24a. v a p 1   Yes	Did tobacco	23d. Date of de Month  Duse contribute to 2 No 3 P  24b. Were a prior to death? 1 Ye:	Approximate Interval Between Onset and Death  Divery Day Year  of the cause of death?  robably 4 Miknown  utopsy findings available completion of cause of second s
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P.O. Box 68	or Attending Physiclan: The law requires that the death certificate be executed after death.  Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to miniorize cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 moorths? 1	Atherosciere Due to (or as a consect of the consect	th. Do not end the Course of t	Ectopic pregnance Other (specify)  Int 3 DOA Oth  Int 3 DOA Oth  Int 28c. Injury  Wor  M 1 29c. Licens	zey  zen in Part I.  26. Place oner: 4 \subseteq Nurs ry at k? lYes 2 \subseteq No ime, date and opinion, death	23e. I 24a. v a 1   Y f Death (Check or ing Home 5   F 28d. Descr 28f. Locatic City or place, and due to occurred at the ti	ory arrest,  Ord tobaccc  Yes  Vas an utopsy erformed?  Position on (Street a Town, Statuth on (Street a Town, Statuth on (ause me, date a me,	23d. Date of de Month  o use contribute to 2 No 3 P  24b. Were a prior to death? 1 Yes  6 Other (Spaury occurred  and Number or Fatte)	Approximate Interval Between Onset and Death  livery Day Year  or the cause of death? robably 4 high windows findings available completion of cause of a 2 No  secify) FLOSPICE  dural Route Number,  as stated. e to the cause(s)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N.S. Rajapakse, M.D. 25 Main St., Suite 200, Reisterstown, MD. 21136

31. Date filed (Month, Day, Year)

JUN 11 2009

32. Refistrar's Signature

Server B. Saule

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 8699 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Month Jack S. Fox 2040 PM 8 6 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore FRANKLIN Square Hospital Center Rosedale If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Nov. 3, 1935 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 1 X M 2 □ F 228-42-2807 73 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 1 ☐ Yes 2 No MD Baltimore Middle River 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21220 USA 422 Brownell Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2X Married 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Sales P&H Auto 1yr 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gladys Steele James A. Fox 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Fox /wife 422 Brownell Road Baltimore MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens of Faith 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 6/12/09 Rossville MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave MD Balto. Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each live. Approximate Interval Between Onset and Death Immediate Cause (Final SesiS Due to ras a consequence of): disease or condition resulting in death) UNKNOW metastatic Carcinoma patic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 2 ☑No 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

**Physician** /Medical Examiner Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Physician/Medical

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Modified Example must be rediffed at once.

Baltimore, Maryland 21215-0036

FOX

signed by the should I eral Director: After th

certificate

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within 24 hours a

To the Funeral C

completely filled

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Completed

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Certification:

Medical

State Registrar

Division of Vital Records, P.O. Box 68760,

IF FEMALE:

27. Manner of Death 1 Natural 5 ☐ Pending investigation 2 Accident

29a. Certifier

6 ☐ Could not be 3 Suicide determined 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Balto md 21237

28d. Describe how injury occurred

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier

29c. License number RES0000

28c. Injury at

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. 1. nom

and manner stated.

DR SIMON I, IRONa

31. Date filed (Month, Day, Year) JUN 1 1 2009

9000 FRANKLIN SQUARE DR 32. Registrar's Signature

For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 2:40 P M 9 2009 Gulley June Grady <u>William</u> /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel 486 Williamsburg Lane 0denton If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 XM 2 □ F Months Days 82 1926 Maryland Director 220-18-9450 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show ir than "natural", or items 23a or 28a-f shov the Medical Examinar must be nutfilled at 1X Yes 2 ☐ No Directo Anne Arundel 0denton Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21113 United States 486 Williamsburg Lane Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 👿 No Specify. þ 3 Widowed 4 Divorced Year or Dates: White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) United States Mental Hygiene. Training Officer Government is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be The1ma Norwood ပ James Gulley Lee Furman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 486 Williamsburg Lane Odenton, Maryland 21113 Nancy L. Gulley/wife 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Ceme 6/15/2009 4 Donation 5 Dother (Specify) Crownsville, Maryland 21. Signa re of Funeral Service License Donaldson Funeral Home & Crematory, P.A. Thomas 1411 Annapolis Road Odenton, Maryland 21113 M00957 uanita 23a. Part i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Malignant Mesothelioma disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2X No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy certificate 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number D17207 June 10, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cancer Center at Johns Hopkins, Baltimore, MD David S. Ettinger, .D. Sidney Kimme1 31. Date filed (Month, Day, Year) 32. Registrar's signatur State JUN 1 1 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** G12055 542 A M CHOL 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard County General Hospital Columbia Howard If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 X M 2 □ F 85 Director 410-30-7614 23, 1924 Tennessee Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location ral", or items 23a or 28a-f show Examinar nust be notified at 10a. State 10b. County 10d. Inside City Limits Director 1X Yes 2 No MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7080 Cradlerock Way, #914 21045 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 1 Yes 2 □ No 1943 If Yes, Give Year or Dates: 1963 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐Yes 2X No Specify White Completed by Specify. 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Ø Sergeant U.S. Army Pages 1 and 2 should be filed went of Health and Mental Hyginant: If Item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) å int of Health and Ment t: If Item 27 Is marked or other traumatic e 2 Josh Gross Geneva Miller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tammy Caurvina/Daughter 6582 Edgewood Road, New Market, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖎 Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Seal Family Cemetery 6/11/2009 Etchison, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, M00770 313 Talbott Avenue, Laurel, MD 23a. Part 1. Enter the disease, or shock, or heart failure. List omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Congestive /Medical Due to (or as a consequence of): Examiner Cardlonyopath Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Myocardial WALL Anterior Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Ps-endemonus phenmonia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Colon (aucer 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? Incufficiency Renal 2 No 1 ☐ Yes 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 1 ☐ Yes 2 🕩 🗖 0 Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

filled in by the within 24 hours a

To the Funeral C

Medical

State Registrar 4 Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier

31. Date filed (Month, Day, Year) 32. Refistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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toward

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0043662

29d. Date signed (Month, Day, Year)

2009

_	1 - State Registrar			Ce	rtificate of	Death		Reg. No	2009	1870
an	1. Decedent's Name (First, Midd MELMARIE		ENTRY				2. Date of D	Da	Year Zi. E'ZiZi	3. Time of Death
al er	4a. Facility Name (If not institution	on, give street and	number)		4b. City, Town, o	or Location of Dea	th		. County of Dea	ıth
	Saint Jose				If I lede 4 Voor	If Under 24 Hr				timore
	5. Social Security Number  213-20-6456  Usual Residence of Decedent	6. Sex 1 ☐ M 2 💢 F		rs. last birthday Yrs.	If Under 1 Year   Months   Days	Hours Mir		av. Year	)   C	rthplace (State or Fore ountry) yland
	10a. State 10b. County	у	10c.	City, Town or L	ocation			<del></del>		10d. Inside City Lim
<b>Funeral Director</b>	-	timore		Baltimo				10 0:		1 □ Yes 2 💢 I
ă	10e. Street and Number 6401 N. Charle	os Straat			10f. Zip Code	21212		10g. Ci	itizen of What Co	•
nera	11. Marital Status	12. Was De	ecedent Ever in	U.S. 13.	Was Decedent of I		Specify Yes or N	0-	14. Race - Ame	erican Indian,
3	1 X Never Married 2  Ma 3  Widowed 4  Divorce	rried 1 ☐ Ye	Forces? s 2 X No Give r Dates:		1 ☐ Yes 2 No		no filcan, etc.)		Black, Whit	nite
etec	15. Decede (Specify only highe	nt's Education est grade complete	ed)	i (Give	edent's Usual Occu kind of work done	during most of we	orking	16b. K	Kind of Business	/Industry
Completed	Elementary/Secondary (0-12)		e (1-4or 5+) Years	iife.	Teacher	*			Education	on
Be C	17. Father's Name (First, Middle		7.041.5			18. Mother's Na	me (First, Middle	e, Maider	n Surname)	
2	William D.	Genti	ry			Mary H	leanor (	O'Coi	nor	
	19a. Informant's Name/Relation		CND		ing Address (Street					
	Sr. Patricia G	illika, S.			N. Charl osition (Name of ematory or other pla		Date	·	ocation - City or	21212 Town, State
	1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (		m State		matory or other pla cia Cemete	i	13-00	Clon	. A M	lowid and
	21. Signature of Funeral Service		ĮV I	11a Mar	2. Name and Addr	ess of Facility	1.5	втеп	Arm, M	aryrand
	I Joseph P	enas	~	l M	2. Name and Addr litchell- 6500 Yorl	Wiedefel k Road	l Funera Baltimor	il Ho e. M	me, Inc Marvland	21212
	23a. Part 1. Frier the disease, of shock, or heart failure. Lis	or complications the	at caused the de	eath. Do not er	A Al					
	Immediate Cause (Final		ii eadii iiile.		iter the mode of dy	ing, such as cardi	ac or respiratory	arrest,		Approximate Interval Between
	disease or condition					ing, such as cardi	ac or respiratory	arrest,		Interval Between
	disease or condition resulting in death)	a. AS		ON PNE	EUMONIA	ing, such as cardi	ac or respiratory	arrest,	55	Interval Between
e.	disease or condition resulting in death)	a. AS Due	FIRATI to (or as a cons	ON PNE equence of):		ing, such as cardi	ac or respiratory	arrest,		Interval Between
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Physicia /Medic		1. Decedent's Name (First, Mi Arthur Gill	espi	Le							Ma	ate of Death ay 28,	2009		12:	me of Death 45 AM M
Examin	er	4a. Facility Name (If not institution College Man				ne				Location of Dea	ath		1	unty of Dea	ore	
Funeral Director		5. Social Security Number 578-66-1199	6. S	ex M∏M2□F	7. Age	(In yrs. la	st birthday) Yrs.	If Unde Months	1 Year Days	If Under 24 Hr Hours Mir	n. No	ate of Birth Nonth, Day, V 6,	Ĭ931	9. Bi Wasi	rthplace (S country) ningor	tate or Foreign n DC
e Maryland a-f show iffied at	ctor	Usual Residence of Decedent  10a. State 10b. Cou  MD Ba1	nty <b>tim</b> o	re		10c. City	Town or Lo	cation onium							1 🗆	ide City Limits
th with the 23a or 28	Funeral Director	10e. Street and Number 300 E. Seim	inar	y Avenu	1e			10f. Zij	Code	21093		10	og. Citizen	of What C		
Irs a	þ	11. Marital Status  1 Never Married 2 N 3 Widowed 4 Divord		12. Was Dec Armed Fo 1Yes If Yes, G Year or D	orces? 2∭N Ive			Was Dece If Yes, spe 1 □ Yes		ispanic Origin? In, Mexican, Pue Specify:	(Specify \erto Ricar	es or No- , etc.)		Race - Am Black, Whi ecify: b		an,
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uld be filed v Aental Hygie rked other t tic event, In	To Be Co	17. Father's Name (First, Midde Arthur Andre	lle, Last)	)		r	la	nasca	iper	18. Mother's N			faiden Sui	rname)		
and 2 shore ealth and N m 27 is maner trauma		19a. Informant's Name/Relati College Mano			lome	T	300	Ĕ. Se	mina	and Number or a	ue L	utherv	ville	, MD	2109	93
it. Pages 1 rtment of H rtant: If ite njury or ot		20a. Method of Disposition  1 □ Burial 2 □ Crematil  4 □ Donation 5 ★ Other	(Specif	in s			ace of Dispo				Date		zuc. Locat	ion - City o	or Town, Sta	ite
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Physician /Medical		23a. Part . Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	, or com ist only	a	Li	the death e. \( \sqrt{\chi}\)	Do not en	ter the mo	de of dyir	ng, such as card	lac or res	piratory arre	est, 		Onset	eximate al Between t and Death
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ficate be exphysician s the burial	ख	resulting in death) Last	l	d	(Or as a	a consequ	ence ory.									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown			birth gnant at	of pregna 2 □ Fetal time of d	death 3[	⊒ Ectopic ⊒ Other (s		у			230	I. Date of c Month	delivery Day	Year
e law requires that the d has been signed by the je 2 should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute  1   1   1   1   1   1   1   1   1   1														
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ysician: s certifii director,	Be	25. Was case referred to med examiner? 1 ☐ Yes 2 ☑ No	ica1	Hospital: 1	lnpatie	nt 2 🗆	ER/Outpatie	nt 3□ D	OA Oth	26. Place of D				Other (S	pecify) AS	sisted
To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification: To	Z LI / tooldelit	estigatio	28a. Date (Mo		y	28b. Time o Injury		28c. Injui Wor	ry at	1	Describe ho				Facility
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<b>₽</b> ₹ <b>₽</b> 8	_	29b. Signature and title of cer	This	yki	ly	(W	220) /T:-	Deice!	23	Si. B		V	NAT	29,	200	9
		30. Name and address of per	64	GA	nc	6	701/	-Ch	roles	y. 6	with	s.m	W 2	120,	£	
Sta	te	31. Date filed (Month, Day, Ye	ear)	A <sup>2</sup> 2.	Registra	r's Sign	ure	N. A								

09-04553 Arthur Goldstein

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 18704

IUI	Goldstein		- For State	Certifica	te of Death		Reg. N	0.	O Time of Doorth
_	Physicia	ın/	Registrar  1. Decedent's Name (First, Middle,Last)	GOLDS	TEIN		2. Date of Death  Month Day  June 8, 2009	y Year	3. Time of Death 0919 hrs
	`Examiı		ARTHUR  4a. Facility Name (if not institution, give		4b. City, Town, or	Location of Death		4c. County of Death	
			I-70 and I-695			Baltimore Cou			
	Funeral		Social Security Number     6. Security Number	7. Age (In yrs. last birth	nday) If Under 1 Year Months Days		1	M/DD/YYYY) 9. Bir Foreig	an l
	Director		577-64-1991 1X	M 2 F 53	Yrs.		09/01/19	55   0	untry) DC
	any		Usual Residence of Decedent  10a. State  10b. County	10c. City, Town o	or Location				10d. Inside City Limits
	*	_	MD N/A	BALT	ΓΙΜΟRE				1 X Yes 2 No
	1arylar 28a-f s 1 at on	Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Cou	intry?
	vith the Maryland s 23a or 28a-f show a notified at once.		3316 CLARKS LAN	E, APT. A	21 13. Was Decedent of His	.215	ecify Yes or No-	USA 14. Race - Ame	rican Indian, Black,
	ath wit items?	uneral	11. Marital Status  1 Never Married 2 Married	Armed Forces?	If Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)	White, etc.	
	fter de l'', or	1	3 Widowed 4 X Divorced	If Yes, Give Year or Dates:	1 Yes 2 X No			Specify: WH	
	nours a natura	ed by	15. Decedent's Education (Specify or	.,	Decedent's Usual Occupa during most of working life	ition (Give kind of v e. DO NOT use reti		b. Kind of Business	rindustry
0	So in 72 h	ompleted	Elementary/Secondary (0-12)	College (1-4 or 5+)	MASHGIACH			MEAT	
2	b-00 ed with tygienc other t	Com	17. Father's Name (First, Middle, Last)				(First, Middle, Main		DOENCTE IN
3	D Z1Z15-UU56 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica	Be	SIDNEY	GOLDSTEIN	b. Mailing Address (Stre	FRAN	CES Rural Route Numbe	r, City or Town, Sta	DSENSTEIN te, Zip Code)
	sho and and nati	1	19a. Informant's Name/Relationship (T FRANCES GOLDSTE	ypo, i iiit /	909 BURNT CF		. SILVER	SPRING.	MD 20903
	ore, M es 1 and 2 of Health If item 2 her traun		20a. Method of Disposition	20b. Place of cremat	of Disposition (Name of co tory or other place)	emetery,	Date 2	0c. Location - City	or Town, State
	MOF Pages ent of int: If		1 X Burial 2 Cremation 3 4 Donation 5 Other Specify	AGUDA	TH ISRAEL CE			ROSEDALE	
:	Baltimore, permit. Pages 1 ar Department of Her Important: If ite		21. a e of Fuheral Service Lice		22. Name and Address	ss of Facility SC	L LEVINS(	ON & BROS	., INC. MD 21208
_	Thysician	-	23a. Part I. Enter the disease, or comp	plic wors that caused the death. Do n	ot enter the mode of dying	g, such as cardiac	or respiratory arrest	, shock, or heart	Approximate Interval Between Onset and
	ledical		failure. List only one cause on e	Probable Multiple Injuries					Death
	_xaminer		or condition resulting in death)	Due to (or as a consequence of):					
		ēr	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):					
		aminer	cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequence of):					
W	executed an and al - transit	<u>~</u>	events resulting in death) Last						
1	exe an a	Medical	UNPENDED	AMENDED				23d. Date of deliv	very.
	3760 ificate b ig physi s the bu	n/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregnancy	y 2 Fetal death 3	Ectopic preg	nancy	Month	Day Year
	Box 687  e death certific  the attending p  ned for use as th	sician/	past 12 months?  1 Yes 2 No 9 Unknow	Pregnant at time of death	5 Other (Specify)				
	the dea ty the a	Phys	Part II. Other significant conditions	9 UIKIOWII	ing in the underlying caus	e given in Part I.			to the cause of death?
	ires that the de signed by the lbe detached f	۾	II.						Probably 4 Unknown
	ords, w requir	1 4					24a. Was autops	y prior	autopsy findings available to completion of cause of
	Pre law ate has	1 6					1 Yes 2		Yes 2 No
	Vital Rec ysician: The his certificate director, page	9		Hospital: 1 Innation 2 FR/		Other Nur		Residence 6 🗸 O	ther: Scene
	of Vit ing Physic After this	[	1 V Yes 2 No	28a Date of Injury 28b	-	njury at Work?	28d Describe h	ow injury occurred	
	on o	ļ <u>ē</u>	1 Natural 5 Pending	Jun 8, 2009 (Month Day, Year)	15 hrs 1	Yes 2 V No	overturned		ck fixed object and
	Division of Vital Records, tal or Attending Physician: The law requints after death and Director: After this certificate has been size in by the funeral director, page 2 should it has the funeral director, page 2 should it	Cortification	2 Accident Investigated Accident Could not be suicide 6 Could not be suicide 6 Could not be suicide as a suicide accident to the suicident to the suicide accident to the suic	ot be 28e. Place of Injury - At home,	, farm, street, factory, offic	ce building, etc.	28f. Location (S or Town, St	treet and Number o ate) I-695, Windsor N	Rural Route Number, City
	Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death within 24 hours after death for the Funeral Director: After this certificate has been signed by the attending physicis from helped by the fineral director.	1	4 Homicide determin	11-1 Interstate	de alle accuració et the timo	date and place a			
	the Ho iin 24 F	Modical	29a. Certifier 1 Certifying Phys one) 2 Medical Examin	ician: To the best of my knowledge, o er:On the basis of examination and/o	death occurred at the time or investigation, in my opin	nion, death occurre	d at the time, date a	and place, and due	to the cause(s)
	To the within To the Countle	Mod	29b. Signature and title of certifier	and manner stated.		ense number		29d. Date signed	(Month, Day, Year)
			Pati a-	tellel -		C.M.E.		June 9, 2009	
30. Name and address of person who completed cause of death (Item 23a)  Patricia Arpnica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201						1			
		Staf	Patricia Arpnica-Pollak Martin (Month, Day, Year)	32. Registrar's Signature					
		Stai ietr	11111 1 1 1	nno Peners D.	barles				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 7:20 PM Ann S. Goolsby JUNE 09 2000 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death St. AGNES HOSPITAL BALTIMORE 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours Min 1 □ M 2 🕅 F 212-30-2154 76 12/04/1932 Maryland Usual Residence of Decedent 10a. State 10c. City. Town or Location 10b. County 10d Inside City Limits 1 ☐ Yes 2 📉 No Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3339 N. Chatham Road Apt. A 21042 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper State Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert Bach Sarah Murphy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Goolsby - Son 7405 Cedar Avenue Sykesville, Maryland 21784 20a. Method of Disposition
1 □ Burial 2 ☐ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Atlantic Crematory LLC 06/12/2009 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
David J. Weber Funeral Homes P.A.
5311 Edmondson Avenue Baltimore, Maryland 21229 21. Signature of Funeral Service Ligensee 93a. Par 1. Enter the disease, con plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PULMONALE DUE TO CHRONIC OBSTRUCTIVE a. COR WEEKS disease or condition resulting in death) Due to (or as a consequence of) PULMONARY DISEASE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □Yes 1 ☐Yes 2 ☐No 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) N Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death

**Physician** /Medical Examiner

. Pages 1 and 2 should be file tment of Health and Mental H tant: If item 27 is marked oth Jury or other traumatic even

Important: If item 27 any Injury or other tr once.

Physician

Examiner

**Funeral** 

Director

"natural", or items 23a or 28a-f show

filed within 72 hours after death with

Maryland 21215-0036

Baltimore,

Director

Funeral

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Completed

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/Medical

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Examiner

Physician/Medical þ Completed B

law requires that the death certificate be execute has certificate this After or Attending death. after death filled in by

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Division of Vital Record

00 σ,

Certification: To

1 Natural 2 Accident 3 ☐ Suicide 4 Homicide ca 29a, Certifier (Check only one) 29b. Signature and title of certifier

State Registrar

5 Pending

investigation

determined

6 ☐ Could not be

M.D

29c. License number P23748

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) JUNE, 09, 2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAJANI JAGANA, St AGNES HOSPITAL, 900 SOUTH CATON AVENUE, BALTIMORE

31. Date filed (Month, Day, Year)

32. Registrar's Signature

within 24 hours a Hospital

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

		State of Maryland / De	partment of Health and <b>l</b> <i>ertificate of Death</i>	Mental Hygiene Reg. No.2009 18705
		Registrar  1. Decedent's Name (First, Middle, Last)	ortinoate of Boatif	2. Date of Death 3. Time of Death
Physi /Med		Jean H. Heifner		June 09, 2009 10:34 A M
Exam		4a. Facility Namé (If not institution, give street and number)	4b. City, Town, or Location of Death	
And the second		492 Orangeville Court	Odenton  If Under 1 Year   If Under 24 Hrs.	Anne Arundel
Funera Directo		5. Social Security Number  6. Sex  1 M 2 M F  7. Age (In yrs. last birthda	Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Ohio
ס		Usual Residence of Decedent		
rrylan Show	Ļ	10a. State 10b. County 10c. City, Town or	Location	10d. Inside City Limits
he Ma 28a-f	Director	MI Antrim	Alden	1 ☐ Yes 2 📉 No
with t		10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
death ms 23	Funeral	7028 Lone Tree Point Lane  11. Marital Status 12. Was Decedent Ever in U.S. 13	49612 3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto	United States  Decify Yes or No- 14. Race - American Indian,
and 21215-0036  be filed within 72 hours after death with the Maryland tall Hygiene.  ad other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at	by Fur	Armed Forces?  1 Never Married 2 Married 1 Yes 2 No If Yes, Give  3 X Widowed 4 Divorced Year or Dates:	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2X No Specify:	o Rican, etc.)  Black, White, etc.  Specify:  White
5-0	Completed	15. Decedent's Education 16a. De (Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of work	16b. Kind of Business/Industry
ithin The han "he	Jg H	Elementary/Secondary (0-12) College (1-4or 5+)	e. DO NOT use retired)	
Hygie ther the		12. 17. Father's Name (First, Middle, Last)	Home Maker	Own Home ne (First, Middle, Maiden Surname)
ed la be	Be	Henry Hornberger		m Gordon
A SEE	٩	· · · · · · · · · · · · · · · · · · ·		ral Route Number, City or Town, State, Zip Code)
<b>≥</b> ₽ <b>=</b> 2 <b>=</b>		Joy Perkins / Daughter 492	Orangeville Court	Odenton, Maryland 21113
ges 1 art of He				Date 20c. Location - City or Town, State
altimore, rmit. Pages 1 ar partment of Hea portant: If item ?		4□Donation 5□Other (Specify) W. Arund	lel Crematory 06-1	1-2009 Odenton, Maryland
Baltimol permit. Pages Department of Important: If it any injury or	S I	21. Signatur of Funeral Service-Lonsee	22. Name and Address of Facility Donaldson Funera 1411 Annapolis R	1 Home & Crematory, P.A. oad Odenton, Maryland 21113
		23a. Pant 1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	Interval Between
Physician	_	Immediate Cause (Final disease or condition resulting in death)  a. Arrhythmia		Onset and Death
/Medica Examine		Due to (or as a consequence of):		
	<u>ē</u>	Sequentially list conditions, if any, leading to immediate  b. Hypertension  Due to (or as a consequence of):		
outed ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		
e exe e exe ian ar urial-tr		resulting in death) Last Due to (or as a consequence of):		
68760, c	edical	d		
	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		and Date of Julius
, P.O. BOX in that the death cert ded by the attending detached for use a	sician/M	in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery  Month Day Year
P.O.	Physi	9 Unknown		
VItal Hecords, P.O. sidan: The law requires that the de certificate has been signed by the rector, page 2 should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown
ecol law req as beer 2 shou	lete			24a. Was an 24b. Were autopsy findings available
The law	Completed			autopsy prior to completion of cause of death?
f VItal F nysiclan: The nis certificate director, pag	Be C	25. Was case referred to medical examiner?	26. Place of Dea	th (Check only one)  1
Of VIta Physician: r this certificarial director, p	2	1 ☐ Yes 2 🕅 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat		ome 5□ Residence 6 XOther (Specify) Home
ath.	ertification:	27. Manner of Death  1 ▼Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day, Year)  28b. Time (Month, Day, Year)		28d. Describe how injury occurred
UIVISION al or Attending s after death. Il Director: Afte	Certific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
LIVISION OF  To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral dir	Medical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.		
To the withing To the comp	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
		> Stall	D60859	06/10/09
15		30. Name and address of person who completed cause of death (Item 23a) (Typ		
	ote	Samana Zulu, MD 7845 Oakwood Road 31. Date filed (Month, Day, Year) 37 Registrar's Signature	d Ste 201 Glen Burn	nie, Maryland 21061
Regis	tate trar	31. Date filed (Month, Day, Year)  31. Registrar's Signature	arked	

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** May /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Future Care Homewood 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1**X** M 2□ F Yrs 85 Director 136-22-3813 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County works r 28a-f sh notified Baltimore Director MD with the 10f. Zip Code 10e. Street and Number "natural", or Items 23a or dical Examiner must be

4c. County of Death If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct 10, Birthplace (State or Foreign Country)
 unk 10d. Inside City Limits 1X Yes 2 No 10g. Citizen of What Country? 21223 USA 1001 W. Pratt Street Funeral unk 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. unk 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White Specify. Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk Be ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Future Care Homewood 2700 N. Charles Street Baltimore, MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Dother (Specify) in state 4 ☐ Donation 23a. Parl 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line.

Immediate cause (Final disease or condition resulting in death)

a. ADVANCED State Anatomy Board 655 W. Baltimore Street Approximate Interval Between Onset and Death (シン)ろのそり Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2No 1 Tes 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Natural 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0554056

Day

2009

24,

5:00 AM M

Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Division or Vital Records, P.O. Box 68760. attending for use as signed by t this After t death. within 24 hours after death

To the Funeral Director:
completely filled in by the

death v

Pages 1 and 2 should be filed within 72 hours afternent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or itelury or other traumatic event, the Medical Examiner

permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau

**Physician** 

/Medical Examiner

Baltimore, Maryland 21215-0036

ss of person who completed cause of death (Item 23a) (Type, Print) Reistorstown Rd Bell MP 32. Registrar's Signature 31. Date filed (Month, Day, **ORIGINAL** 

State Registrar

30. Na

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 5:30 A M Francis Hinkleman, 2009 8 June 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Transitions Health Care Sykesville Carrol1 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Months Days Hours Min. 1X M 2□ F 30 1941 219-26-5948 67 Aug. Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 X No Prince George's Laurel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6404 Darwin Road 20707 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married If Yes, Give X Year or Dates: 1 ☐ Yes 2 No Specify. White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John F. Hinkleman, Sr. Ruth Vinson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13225 Old Frederick Road, Sykesville, MD David Charles Hinkleman/Brother 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State West Arundel Crem. 6/11/2009 Odenton, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Donaldson Funeral Home, P.A. M00770 313 Talbott Avenue, Laurel, MD 20707 Approximate Interval Between Onset and Death 23a. Part 1. Erter the disease, shock, or heart failure. L complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a nsequence of): who Sequentially list conditions Due to (or as a consequence of): it and, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): itcome of pregnancy birth 2 Tetal death 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year nant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

MD

Funeral

Director

28a-f shov

ō items 23a

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"natural"

permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nat any Injury or other traumatic event, the Modes.

Director

Funeral

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Completed

Be

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traumatic event, the Medical Examiner must be notified at

72 hours after

Baltimore, Maryland 21215-0036

Physician: The law requires that the death certificate be executed sician and burial-trans P.O. Box 68760, the, attending philor use as the signed by the a Records, Division of Vital

Hospital or Attending

the

page 2 s funeral director, this within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

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Certifica

Medical

Examiner

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FEMALE:  3b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, ou 1 ☐ Live 4 ☐ Preg 9 ☐ Unkı
art II Other significant conditio	ns contributing to d

24a Was an autopsy 1 ☐Yes 2 🔀 No

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 2/ No 1 Tyes

25. Was case referred to medical examiner? 1 ☐ Yes 2 **□**₩6

Hospital: 28a. Date of Injury (Month, Day, Year) 5 ☐ Pending investigation

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28b. Time of Injury 1 ☐ Yes 2 ☐ No

Other: 4 Linuxing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

29a Certifier

27. Mann of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

JUN 1 1 2009

6 ☐ Could not be determined

050763

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Machinesty 31. Date filed (Month, Day, Year)

Naptr 32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

EANESTO mendon

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Of IVID Registrar		ertificate of Death	·	Reg. No 2 0 0 9	18709
	Physici		1. Decedent's Name (First, Middle, Last)  ALMA V. JENKINS	2. Date of De Month	Day Year	3. Time of Death		
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of		4c. County of Dea	1
1			VINDOBONA		Braddock Heig		Frederic	
	Funeral Director		577-28-8300 1□M 2⊠F	91 Yrs.	) If Under 1 Year If Under 2 Months Days Hours	Min. 8. Date of Bir (Month, Da Apr. 1	8, 1918 Vi	thplace (State or Foreign ountry) rginia
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Le	ocation			10d. Inside City Limits
	Mary a-f sh	tor	VA Lancaster	Kilmarno	ock			1 □Yes 2XINo
	or 28g	Director	10e. Street and Number	11111111111111	10f. Zip Code		10g. Citizen of What Co	ountry?
	ath wi		300 Avonne Avenue		22482		USA	
036	filed within 72 hours after death with the Maryland Hyglene. other than "natural", or Items 23a or 28a-f show ent, the Mydcal Evar, it or roust be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 XWidowed 4 Divorced  12. Was Decedent E Armed Forces?  1 Yes, 2 XW If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican, 1 □ Yes 2 ☑ No Specify:	in? (Specify Ye's or No Puerto Rican, etc.)		
9500-51212	be filed within 72 ho ntal Hygiene. d other than "natul event, the Madical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5-	+) (Give	edent's Usual Occupation e kind of work done during most DO NOT use retired) Cher	of working	16b. Kind of Business	•
פַ		Be C	17. Father's Name (First, Middle, Last)	1200		's Name (First, Middle		
ylar	2 should be and Mental Is marked o aumatic eve	10 E	George Frank Blosser		Mar	y Pinehart		
, Maryland	tra tra		19a. Informant's Name/Relationship (Type. Print) Gary L. Jenkins/Son		ing Address (Street and Number		er, City or Town, State, 2 22482	Zip Code)
more,	permit. Pages 1 and Department of Heal Important: If item 2 any Injury or other Once.		20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispose Kilmarno	mataniar other place)	Date -10-2009	20c. Location - City or Kilmarnock	·
Baltimor	permit. Departm Importa any Inju		21. Signal or of Funeral Service Licensee	2	2. Name and Address of Facility O Box 1275, Ki		ineral Home	, LLC
Ħ			23a Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	the death. Do not en	nter the mode of dying, such as			Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a	men(t)	&			Onset and Death Now THI
	Examiner	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence of):	onbeshing	Dound	0	MONTHS
9	executed and al-transit	edical Examiner	triat initiated events	a consequence of):				
58/50,	rificate be executed g physician and as the burial-transit		<b>d</b>					
	he death certif the attending ched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 12 No 9 □ Unknown  23c. If yes, outcome to 1 □ Live birth to 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3	□ Ectopic pregnancy □ Other (s <i>pecify</i> )		23d. Date of de Month	livery Day Year
z,	ires that t signed by I be detac	<u>۾</u>	Part II. Other significant conditions contributing to death but a gentive Hewt Pac	it not resulting in the u	underlying cause given in Part I.		obacco use contribute to Yes 2 □ No 3 □ P	
cords	v requ	etec	Journe Service	w				
E LE	: The lav icate has page 2	Completed		,		24a. Was autoj perfo 1 □Yes	psy prior to death?	utopsy findings available completion of cause of
Ĭ	<u>a</u> <u>‡</u> a <u>a</u>	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatier	nt 2 ☐ ER/Outpatie	0.0	of Death (Check only o		9.0
	slc slc irec			nt 21 IER/Outbatie	nt 3 DOA 4 Nur	sing Home 5 ∐ Resi	dence 6 Other (Spe	ecify)
0 0	ding Physici	၉	27. Manner of Death 1 Natural 5 □ Pending 28a. Date of Injur (Month, Day	y 28b. Time o	Work?	28d. Describe	now injury occurred	
DIVISION OF	I or Attending Physician: The law requires that the death cer acted the the state of the control	၉	27. Manner of Death  1 Natural 5 Pending (Month, Day  2 Accident investigation	y (Year) 28b. Time of Injury	Work? M 1 □Yes 2 □ N	О	Street and Number or R	
DIVISION OF	e Hospital or Attending Physici 24 hours after death. e Funeral Director: After this ca letely filled in by the funeral direc	Certification: To	27. Manner of Death    Natural   5   Pending   (Month, Day)   Accident	y, Year) 28b. Time of Injury  ry - At home, farm, st. (Specify)  of my knowledge, dear examination and/or in	M	28f. Location ( City or Tou	Street and Number or Riwn, State)	ural Route Number,
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DIVISION OF	To the Hospital or Attending Physici within 24 hours after death.  To the Funeral Director: After this ce completely filled in by the funeral directors.	edical Certification: To	27. Manner of Death  1	y, Year)  28b. Time of Injury  ry - At home, farm, st. (Specify)  of my knowledge, dear examination and/or inted.	M 1	28f. Location ( City or Total d place, and due to the h occurred at the time,	Street and Number or R. wn, State)  cause(s) and manner a date and place, and due 29d. Date signed (Montal)	ural Route Number, s stated. e to the cause(s) th, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Physician 4:08 P.M James L. Johnson 2009 June 8, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Towson Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number 6. Sex Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 214-44-8553 1 M 2 □ F 65 Yrs. Balt., 11/20/1943 Maryland **Director** Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Wedical Evantibut at 1 ☐ Yes 2 ◯XNo Maryland Baltimore Baltimore Director 10g. Citizen of What Country? United States of America 10f. Zip Code 10e. Street and Number 1321 Willow Road 21222 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White If Yes. Give þ 3€XWidowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) and 2 should be filed within lealth and Mental Hygiene. m 27 Is marked other than ' Elementary/Secondary (0-12) Bethlehem Steel Electrical Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James H. Johnson Rose Mosscariello 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health a item 27 Is Baltimore, Maryland 21222 Mrs. Jamie L. Stehli/ daughter 1321 Willow Road permit. Pages 1 a
Department of HeImportant: If item
any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral
Chapel – Bel Air 20c. Location - City or Town, State 20a Method of Disposition June 10. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Forest Hill, Maryland 2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fund al Service Licensee 22. Name and Address of Facility Peaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ASPIRATION PNEUMONIA DAYS **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner 2005 Due to (or as a consequence of): Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transi and Due to (or as a consequence of): P.O. Box 68760. attending physician The law requires that the death certificate be Physician/Medical as the l IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy for Month Day Year 5 Other (specify) ☐Yes 2 ☐No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ EMPHYSEMA yes 2 No 3 Probably 4 Unknown Completed certificate has been CORONARY ARTERY DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 164395 JUNE 9, 2009 person who completed cause of death (Item 23a) (Type, Print) 30. Name and address 555 W. TOWSONTOWN BLUD BALTIMORE, MD 21204 5

State Registrar

31. Date filed (Month, Day, Year)

DOBERMAN, MD 555 W. TO ay, Year) 32. Registrar's Signature factor

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of <b>60</b> , ate be exented at the burial-to burial-to
DIVISION OF VITAL RECORDS, P.O. BOX 68  To the Hospital or Attending Physician: The law requires that the death certifics within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as it
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		Registrar  1. Decedent's Name (First, Middle,	(act)			Dealli	2. Date of Death	g. No. 2 1 1 9	3. Time of Death	
Physic /Med		Larry	R.	John	nson, Sr.		June 8,	Day Year	4:29P M	
Exam		4a. Facility Name (If not institution,	-		,.	or Location of Death	1	4c. County of Deat		
regar <sup>a</sup>		1208 Whitman Dr				Burnie		Anne Arui		
Funera Directo		5. Social Security Number 220–36–1564	6. Sex 7. Ag	e (In yrs. last birthe	Months   Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug. 29,	Year)   Co	hplace (State or Foreign untry)	
pu »		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town o	r Location				10d. Inside City Limits	
faryla	٥	,	Arundel		Burnie				1 □Yes 2X No	
the N	Director	10e. Street and Number		Gien	10f. Zip Code		10	ng. Citizen of What Co	untry?	
with Sa or	Ö	1208 Whitman Dr	1170		21061			J.S.A.	,	
ns 2:	Funeral	11. Marital Status	12. Was Decedent I	Ever in U.S.	13. Was Decedent of If Yes, specify Cub	Hispanic Orlgin? (S		14. Race - Ame	rican Indian,	
or ite	Ē	1 ☐ Never Married 2 ☐ Marrie	Armed Forces? ed 1 ☐ Yes 2 1 1	No			o Rican, etc.)	Black, White	e, etc. nite	
5-UU30 72 hours after death with the Maryland natural", or items 23a or 28a-f show ulgal Even in the retilised at	d by	3 □XWidowed 4 □ Divorced	If Yes, Give Year or Dates:		1 □Yes 2 2 No	Specify:		Specify: WI	11100	
72 hc	Completed	15. Decedent's (Specify only highest	s Education t grade completed)	16a. D	ecedent's Usual Occu Give kind of work done fe. DO NOT use retire	pation during most of worl	king I	6b. Kind of Business/	Industry	
vithin sne.	E G	Elementary/Secondary (0-12)	College (1-4or 5	)+)	fe. DO NOT use retire ick Driver	ed)		Transporta	ation	
Hygie Ther ther ther	ပ္သ	17. Father's Name (First, Middle, L	ast)	TE	ick briver	18 Mother's Nam	ne (First, Middle, M		201011	
land ld be file ental H ked oth Ic event	To Be	Marvin Johnson					t M. Wrig			
ary shou and M s mar umat	-	19a. Informant's Name/Relationsh	ip (Type. Print)	19b. N	lailing Address (Stree	t and Number or Ru	ral Route Number,	City or Town, State, 2	Zip Code)	
and 2 auth 2 satth 3		Mrs. Hazel S. S	tone/ Daugh	ter   12	208 Whitman	n Drive G	len Burni	le, Marylan	nd 21061	
of He fitem		20a. Method of Disposition	2 DRamoual from State	20b. Place of D	isposition (Name of crematory or other pla	ce) Jun	e II,	20c. Location - City or		
Pag ment ant: I		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp			idge Mem.	i n	009 É	Elkridge, N	AD .	
DESILITIONEY, INTERLYIER ZIZIS-UUSO  permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, in Marical Eventual.		21. Signature of Funeral Service L	A /I				_	Funeral & (		
	1	Me de la company		220				and the second second	Approximate	
		23a. Part1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final	only one cause on each lir	ne.	G			est,	Interval Between Onset and Death	
Physician /Medical	_	disease or condition resulting in death)	_ a		RY FA	F1 C 0 126			1-2 WEEKS	
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THE REAL PROPERTY.	<u>ē</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence of)		- 1021	014111	132112	111107 10110	
cuted nd ransit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С.							
be exe		resulting in death) Last	Due to (or as	a consequence of)						
BOX 00/00, eath certificate be executed attending physician and for use as the burial-transit	dical		d							
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Sy that so that and an are det	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death?		
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law r nas be	Completed						24a. Was an	prior to	topsy findings available completion of cause of	
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This rate of	٦.	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatie		atient 3 L DOA	4 ☐ Nursing H	ome 5 Reside	nce 6 Other (Spe	cify)	
ding th. : Afte	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Da		ry Wo	rk? ∐Yes 2 □ No	Est. Describe no	w injury occurred		
Atter er dea ector by the	iffica	3 Suicide 6 Could no 4 Homicide determin	ot be 290 Place of Inju	ury - At home, farm	, street, factory, office	-	28f. Location (Str	reet and Number or Ri	ural Route Number,	
tal or rs after all Dir	Certification:	4 Difformate	building, etc	c. (Opecity)			City or Town	, State)		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier  (Check only one)  Certifying  Medical E	g Physician: To the best Examiner: On the basis o and manner sta	f examination and/	leath occurred at the or investigation, in my	time, date and place opinion, death occu	e, and due to the ca arred at the time, da	ause(s) and manner a ate and place, and due	s stated. e to the cause(s)	
To th Withir To th	Me	29b. Signature and title of certifier	7-15			se number	29	od. Date signed (Mont	h, Day, Year)	
( -		1 land	16/20.			9807		6/9/09		
5XV		30. Name and address of person w	ho completed cause of d	eath (Item 23a) (Ty	pe, Print)	0 . 4 1	1 1 1511	000000000000000000000000000000000000000	1) 2	
St	tate	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	· 706 S. CR	MIN ITWY	GLEN I	DU FIVE TO	EDI 2106/	
Regist		THE T	2009 Pere	ur S.	Sale				13. 2106/	
DHMH 17 Bev 1/	/2001	AQII * *	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2009 Year 9 June Michael Patrick Jordan 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 506 Theresa Avenue Essex Baltimore If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Months Days Hours 217-80-7589 **№** M 2 🗆 F Dec.29 MD 35 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Baltimore 1 ☐ Yes 2 No MD Essex 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 506 Theresa Avenue 21221 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify. If Yes, Give Year or Dates: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Contracting 2yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert Jordan Jr. Deborah Hurley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cypress Lane Baltimore MD 21220 Deborah Jordan-Myerovitz 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date Bayview Crematory I ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD 101 P0 5 ☐ Other (Specify Donation 22. Name and Address of Facility 300 Mace Ave.Balto. Connelly Funeral Home of Essex 21221 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ribute to the cause of death? 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No noute Number 2

Physician /Medical Examiner

permit. Pages 1 and 2 s Department of Health a Important; If item 27 is any injury or other trau once.

Physician

/Medical

**Examiner** 

Director

Funeral

Completed by

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Exami

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant; If item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, the Medical Examinations to be notified at

Baltimore, Maryland 21215-0036

law requires that the death certificate be executed burial-tran attending physician for use as the buria - use ed by the a s been signed be should be deta

Box 68760,

P.0.

Division of Vital Records,

age 2 s certificate has To the Hospital or Attending Physician; The I within 24 hours after death.

To the Funeral Director: After this certific te ha ours after death.

eral Director: After this certific filled in by the funeral director,

Physician/Medical Medical Certification: To Be Completed by

Part II. Other significant conditions of	23e. Did tobacco use contribute to the cause of de 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ U			
		24a. Was an autopsy findings a prior to completion of ca death?  1 □ Yes 2 No 1 □ Yes 2 No		
25. Was case referred to medical	26. Place of Death (	Check only one)		
examiner? Yes 2 ☐ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	e 5 Residence 6 □ Other (Specify)		
27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day, Year) Injury Work?	d. Describe how injury occurred Suicide		
3 Suicide 6 □ Could not b 4 □ Homicide determined	280 Blood of Injury. At home form street factory office.	f. Location (Street and Number or Rurel Route Numb City or Town, State) 5010 WARS SC		
	nysician: To the best of my knowledge, death occurred at the time, date and place, ar niner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.			

State Registrar

completely

29c. License number

29d. Date signed (Month, Day, Year)

29b. Signature and tipe of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day **Physician** М June 9 2009 1313 Mary Catherine Kilner /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Harford Upper Chesapeake Medical Center Bel Air 8. Date of Birth (Month, Day, Year)

July 18, 1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🕅 F Yrs. 1925 Maryland Director 83 214-20-9978 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar runst be notified at 1 ☐ Yes 2☐ No Director Maryland Harford Bel Camp 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1313 Cranesbill Court #103 21017 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ [X]No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TXNo Specify: Specify Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Telecommunications 12 Telephone Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Connelly Edward Branning ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau 1313 Cranesbill Court #103; Bel Camp, MD 21017 Mary Kathleen Kilner-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 6/15/2009 Bear, Delaware Delaware VA Mem. Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Cervice Liver Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Shock SEPTIC ZYPAG E disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it is a pleasing to infine distance. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed and burial-tran Due to (or as a consequence of): the attending physician hed for use as the burial Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mon 1 ☐ Yes 2 No Month Year 5 Other (specify) P.0. 9 Unknown 9 Unknown signed by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, icate has been siç 7, page 2 should b 1 ☐ Yes 2 ☐ Wo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed certificate 1 ☐ Yes 2 € No 1 □ Yes of Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2⊠No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of te Hospital or Attending P n 24 hours after death. te Funeral Director: After t oletely filled in by the funera 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier Takertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 the

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Soó

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Birnbaum

m. D. 500 L

32. Registrar's Signature

2009

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Silner,

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 (1) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Day Year 09, 2009 Parkash Kaur June 2:38 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1 □ M 2 🛛 F Director 212-08-1944 85 1-8-1924 India Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at Director 1 ☐ Yes 2 No MD Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 4521 East West Highway #807 Funeral 20814 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after near of Health and Mental Hygiene. Instit If item 27 is marked other than "natural", or ite ury or other traumatic event, Ire Medical Examina 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2X No Specify. Asian Indian \$ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Rishpal Singh Gurnam Kaur 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tr once. J. K. Nepal / Step-Son 14 Cathedral Court Clifton Park, New York 12065 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arundel Crematory 06-11-2009 Odenton, Maryland Funeral Service License 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sepsis disease or condition resulting in death) days /Medical Due to (or as a consequence of): Examiner Urinary Tract Infection Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) signed by the aftending physician and the detached for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à ficate has been się r, page 2 should b Chronic Kidney Disease, Hypothyroidism 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate performe Division of Vital 2 X No 1 ☐ Yes 2 ☐ No 1 □Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 XNatural 2 ☐ Accident 1 ☐ Yes 2 ☐ No filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only To the within 2 re and title of certifier 29b. Signa 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

JUN 1 1 2009

Eric J. Park,

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

8600 Old Georgetown Road Bethesda, Maryland 20814

02:38 AM

aur, Parkash

D0060117

June 09, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Rosie Khouw рм 9, 3:50 2009 June /Medical 4c. County of Death 4h. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Ellicott City Howard 2823 Green Shade Court If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/12/1919 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 286-50-1730 1 M 2 X 90 China Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD Ellicott City Howard 1 ☐Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 2823 Green Shade Court 21042 Funeral within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Asian Specify 3 3 XWidowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be unknown unknown ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra 2823 Green Shade Court, Ellicott City, MD 21042 Albin Khouw / 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buria! 2 XCremation 3 ☐ Removal from State Ardent Crematory 6/10/2009 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) Crota Marshall 22. Name and Address of Facility
Maryland cremation Services 21. Signature of Funeral Savice Licensee PO Box 1413, Baltimore, MD 21203 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death Physician /Medical resulting in death) (or as a consequence of) Q. Examiner Esquentially list or ditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown been signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has b autopsy performed? Yes 2 No certificate 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatura and the of

State Registrar

Registrar III 1 2000

31. Date filed (Month, Day, Year,

B2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>009</u> **Physician** June 6, 10:48 P.M **JEANNE** ARTHUR /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** <u>Baltimore</u> Gilchrist Hospice Care Towson 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🗓 F Months Yrs Director 214-54-2640 59 June 29, 1949 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f shov Examiner ust be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Towson 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 700 Camberly Circle Completed by Funeral 21286 U.S.A. Apt. A-6 12. Was Decedent Ever in U.S.
Armed Forces?
1 Yes 2 No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 □ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 5+ years and Mental Hygiene. Primary Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be f Health and Mental I ည Paul Stewart Arthur Jeanne Meeth 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) pernit. Pages 1 and 2.
Depertment of Heaith a Important: If item 27 is any njury or other tra Matthew P. Kluga 7117 Heathfield Rd. Baltimore, Maryland 21212 20a. Method of Disposition Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cemetery 6-12-09 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility.
Mitchell-Wiedefeld Funeral Home, Inc. 23a. Part 1. Extended a Baltimore, 18 shock, or heart failure. List only one cause on each line. 6500 York Road Baltimore, Maryland Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) COLON CANCER **Physician** MONTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Sequentially list condition and a year of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Disastic for as a envisable consider the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical nse 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy detached for in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 No the 9 Unknown signed by Hospital or Attending Physician: The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an has autopsy performed? 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) JUNE 7, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 NCHAPUS ST, SUITE 4105 TUBEN, MO 21204 mo

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

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Denve B. fares

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State Registrar	State of Marylan		artment of F			iene2 ()	09 18	717
Ī	Physicia	an	1. Decedent's Name (First, Middle, Last) Edith W. Knife					2. Date of Deat Month June 1,	Day	3. Time of 8:30	
>	/Medic Examin		4a. Facility Name (If not institution, give st	treet and number)	1	4b. City, Town, o	r Location of De		4c. Count		1111
•	LAGITUIT	CI	10450 Lottsford			Mitch	ellvill	.e	Princ	e George's	
	Funeral Director		5. Social Security Number 6. Sex 083-10-9892 1□	M 2XIF 7. Age (In yrs. 1	* 1	Il Under 1 Year Months Days		Hrs. 8. Date of Birth (Month, Day) Aug 30	<sup>Year)</sup> 1916	9. Birthplace (State of Country) New York	or Foreign
	M M		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside C	ity Limits
	f eho	Į.	MD Prince Ge		chelly						2√□ No
3	a or 28a-	Director	10e. Street and Number 10450 Lottsford F			10f. Zip Code 207	'21	1	0g. Citizen of USA	What Country?	
2	permit. Pages 1 and 2 should be tied within 72 hours atter death with the maryland Depertment of Health and Mential Hygiene. Depertment of Health and Mential Hygiene. Important: If them 27 is marked other then "natures"; or Itema 23a or 28a-f show any injury or other traumatic event, It a Michical Examinar must be notified at once.	y Funeral	1 Never Married 2 Married	2. Was Decedent Ever in U. Armed Forces? 1 Yes, 2 No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cub 1 ☐ Yes 2X No		(Specify Yes or No- uerto Rican, etc.)		ce - American Indian, ick, White, etc. fy: White	
3	turel',	ed by	3 Widowed 4 □ Divorced  15. Decedent's Educ		162 Dogge	dent's Usual Occup		unk		Business/Industry	unk
2	within 72 ene. then "nai	Completed	(Specify only highest grade	Completed)  College (1-4or 5+) 5+	(Give	kind of work done OO NOT use retire	during most of		196. Kirid Of E	susmess/moustry	<b>3</b>
ומוומע	uld be filed flental Hygi rked other lic event, I	To Be Co	17. Father's Name (First, Middle, Last)  James Henry Burk					Name (First, Middle, I		me)	***************************************
Mary	of 2 should had had had he maintained had had had had had had had had had ha		19a. Informant's Name/Relationship (Type Carol Delany/niec		19b. Mailin 3001	ng Address (Street Veazey T	and Number or errace	Rural Route Number NW Washing	c, City or Town	, State, Zip Code) C 20008	
allillore,	Pages 1 arent of Healur: If Item:		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☑ Donation _5 ☐ Qther (Specify)	1 ^	lace of Dispo emetery, cren	sition (Name of natory or other pla	сө)	Date	20c. Location	- City or Town, State	
	Depermit. Depertmin importal any injuit		21. Signatur of Funeral Service License Ronald S			Name and Address ate Anat Itimore.		rd 655 W.	Baltim	ore Street	
, j	nysician		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition	eations that caused the death						Approxima Interval Be Onset and	tween
~	/Medical Examiner	Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (1r as a consequence of the consequence of t		He	1 (2)	dise	-e_	y/ 9	5-
0 / 0	cate be executed physicien and the burial-transit		L d.								
O. DOX O.	Ine law requires that the deeth certificate be executed title hes been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	Bc. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3	Ectopic pregnanc Other (specify)	у			ate of delivery onth Day	Year
Cids, T	ures that signed b id be deta	Ď	Part II. Other significant conditions conf	tributing to death but not res	ulting in the ur	nderlying cause gr	ven in Part I.		bacco use cor	ntribute to the cause of	
ו הפנט	Ine law req ete hes beer page 2 shou	Completed						24a. Was a autop: perfor	sy med?/	. Were autopsy lindings prior to completion of death?	s available cause of
1	Physician: The this certificate he al director, page	Be	25. Was case referred to medical examiner?					Death (Check only or	10)		
5 7	rnyst this c at dire	2	1 ☐ Yes 2 ☑ No		ER/Outpatien	IL 3L DOA		g Home 5 Resid			
5	After funer	tlon	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	Wo	rk? ]Yes 2∐No	200. Describe in	ow injury occu	1100	
	efter deal Olirector: 3 in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specification)	ome, larm, str y)			28f. Location (S City or Tow		nber or Rural Route Nur	mber,
- :	To fine Hospital or Attending Prysician: within 24 hours elter death. To the Funeral Director: After this certifica completely filled in by the funeral director. I	edical Co	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, death tion and/or in	n occurred at the ti vestigation, in my	me, date and proprinted the control of the control	lace, and due to the coccurred at the time, o	ause(s) and n date and place	nanner as stated. , and due to the cause(	(s)
	Mithin Youngle	Me	29b. Signature and title of certifier	^		29c. Licen	se number	0	29d. Date sign	ed (Month, Day, Year)	~ ·
	- , 3		NAM			0	119	28	6-3	-200	1
			30. Name and address of person who co	mpleted cause of death (Item	23a) (Type,	Print)	norfs	lis Rd	# 22	28 C)en	Dule
	Sta Registr		31. Date liled (Month, Day, Year)	32. Registrar's Signa	ture	ed .	,			MS 207	169

)9-04485	Please Type or Print in Black Indelible Ink. Ensure All Cop	
	For State Certificate of Death	Reg. No. 2009 1871
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last)  Ted Michael Kardash	2. Date of Death Month Day Year 1310 hrs
(	4a. Facility Name (if not institution, give street and number)  6921 East Baltimore Street  4b. City, Town, or Location of De	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Months Days Hours	Min. Country)
Director	Usual Residence of Decedent	Aug.29,1959 MD
ow any	10a. State 10b. County 10c. City, Town or Location Baltimore Baltimore	10d. Inside City Limits 1 X Yes 2 No
the Maryland to 28a-f shu tified at once	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
death with the Maryland or items 23a or 28a-f show any must be notified at once.	6921 East Baltimore Street 21224	USA
or items 23 must be no Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? 1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Pu	
s after de rall, or i	1 Yes 2 X No 3 Widowed 4 Divorced If Yes Rive Year 1 Yes 2 X No specify:	Specify: White
hours a	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)	
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	12th College (1-4 or 5+) Glazer	Collins Glass
21215-0036 uld be filed within 7 Mental Hygiera marked other than c event, the Medica fo Be Comple	Tamor Vardach	ame (First, Middle, Maiden Surname)
2121 ould be fil ould be fil ould be fil s marked lic event,	1 11	dna Sawyer or Rural Route Number, City or Town, State, Zip Code)
MD  1d 2 sho alth and m 27 is aumatic		Lane Baltimore MD 21221
Baltimore, permit. Pages I ar Department of Hee Important: If Tiel injury or other tr	20a. Method of Disposition  1 XBdrial 2 Cremation 3 Removal from State  4 Projection 5 Other Scotting  20b. Place of Disposition (Name of cemetery, crematory or other place)  Holy Trinity Cemeter	Date 20c. Location - City or Town, State
Baltim permit. Pa Departmer Importani injury or o	4 / Dunation Sy / Tother Specify. /	300 Mace Ave. Balto. MD
		neral Home of Essex 21221
/Medical	failure. List only one cause on each line.	Between Onset and
xaminer	Immediate Cause (Final disease or condition resulting in death)  a.   GOM IICATIONS OF CRYONIC ALCOROL  Due to (or as a consequence of):	
ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
ted misit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying (Disease or injury that Cause	
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760, cate be physicia he buria	IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery
ox 68760, and certificate be attending physici for use as the buri	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic prepared time of death 5 Other (Specify)	egnancy Month Day Year
D. Bo): the death by the att ached for Physi	1 Yes 2 No 9 Unknown 9 Unknown	23e. Did tobacco use contribute to the cause of death?
s, P.O. Baires that the designed by the detached for be detached by the detached for by Physical by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1 Yes 2 No 3 Probably 4 Unknown
Records, The law require, ficate has been sig, page 2 should be		24a. Was an autopsy findings available prior to completion of cause of
Vital Reco ysician: The law his certificate has director, page 2 s		performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
Vital hysician: this certiful director	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other, 4 N	eck only one)  ursing Home 5 Residence 6 ✔ Other: Scene
1 of V Jing Phys After thi funeral di	27. Manner of Death  28a. Date of Injury  28b. Time of Injury  28c. Injury at Work?	28d. Describe how injury occurred
ivision or Attend after death. Director: I in by the f	1 X Natural 2 Accident 5 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City
Division o spital or Attending hours after death neral Director: Aft filled in by the fime Certification:	Suicide  4 Homicide  6 Could not be determined (Specify)	or Town, State)
	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	
To the Ho within 24 To the Fu completel	and manner stated.  29b. Signature and title of certifier  29c. License number	29d. Date signed (Month, Day, Year)
	Patri () - Pollel us O.C.M.E.	June 6, 2009
æ v	<ol> <li>Name and address of person who completed cause of death (Item 23a)</li> <li>Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltin</li> </ol>	more, MD 21201
State	31. Date filed (Month, Day, Year) 2000 32. [fegistrar's Signature]	

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Dav **Physician** 9:29A M Alma Durell Hubble Law 5, June 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 4050 Prospect Mill Road Whiteford Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 1 □ M 2 🛛 F Director 173-24-8540 April 16,1915 Rochester, NY Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits items 23a or 28a-f show ner roust be notified at 1 □Yes 2 No Director Harford Whit eford MD 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 21160 4050 Prospect Road U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □Yes 2 No If Yes, Give 1 Never Married 2 Married other traumatic event, the Medical Exami 1 ☐ Yes 2X No ģ Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) At Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nathaniel David Hubble Durell Mendexter Hayden ల 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Law Jaffe/ Daughter 412 August Street, Easton, MD 21601 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date Department of Important: If it any injury or o Evans Funeral Chapel Bel Air 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 06/10/09 Forest Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services 8800 Harford Road, Parkville, MD 21234 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day Vear 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy Certification: To

**Examiner** burial-trar P.O. Box 68760. Division of Vital Records, After this

Maryland 21215-0036

Baltimore,

death.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after deatl To the Funeral Director:

											1 ⊡Yes	2 No		Yes	2 🗆 No	
25	. Was case references	red to medical						26.	Place of Dea	th (Ch	eck only	one)				
	1 Yes 2	No	Hospital	1 ☐ Inpatient 2 ☐	ER/Outpatient	3 🗆 [	DOA Ot	ner: 4	□ Nursing H	lome	5 Res	sidence	6 □Other	(Speci:	fy)	
	. Manner of Deat 1 X Natural 2 Accident	5 Pending investigation		Date of Injury (Month, Day, Year)	28b. Time of Injury	М	28c. Inju Wo 1 E		2 □ No	28d.	Describe	how injur	y occurred	ı		
	3 Suicide 4 Homicide	6 Could not be determined	28e.	Place of Injury - At he building, etc. (Special	ome, farm, stree	t, facto	ory, office			28f. I	ocation City or To	(Street an own, State	d Number	or Rura	al Route Numb	ber,
29	a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exar	niner: Or	To the best of my known the basis of examination	owledge, death of ation and/or inve	occurre	ed at the ton, in my	ime, o	date and place on, death occu	e, and urred a	due to th t the time	e cause(s e, date and	) and man d place, an	ner as s	stated. o the cause(s)	)

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

Medical

29b. Signatur

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2009 A M Michael June 4:45 Litzau Sr. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 7312 Geise Avenue Edgemere Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 🕅 M 2 🗆 F 214-50-2093 October 30, 1963 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 No Baltimore Maryland Edgemere 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7312 Grise Avenue 21219 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 □No 1 ☐ Yes 2 🛣 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 years Heavy Equipment Operator Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Howard J. Litzau Rosmary Buccini 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tamara Riley Fiancee' 7312 Geise Avenue, Edgemere,Maryland 21219 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June 11, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, Maryland 2009 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Connelly Funeral Home Of Dundalk, P. A. 7110 Sollers Point Road, Dundalk, Md. 23a. Part 1. Enter the disease, or v mplications that caused the death. To ot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SARCOMA OF CHEST WALL MONTHS disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy perform 2 **X**No 1 ∐ Yes 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred

The law requires that the death certificate be executed attending physician and for use as the burial-tran Box 68760 P.0. signed by the at be detached f of Vital Records, should ! has e 2 s page his certificate h I director, page Hospital or Attending Physician: After th funeral Division ours after death.

leral Director: A
filled in by the fu

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

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Examiner

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Certification: To

Medical

ir than "natural", or items 23a or 28a-f shorthe Medical Evanther is ust be notified at

permit. Pages 1 and 2 should be filed within 72.

Department of Health and Mental Hygiene.

Important; If item 27 is marked other than "na any Injury or other traumatic event, the Media Other.

**Physician** 

/Medical

Examiner

hours after

Baltimore, Maryland 21215-0036

27. Manner of Death Natural

29a. Certifier

25. Was case referred to medical examiner? 2 Accident

5 Pending investigation 6 ☐ Could not be 3 ☐ Suicide determined 4 Homicide

28a. Date of Injury (Month, Day, Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes

2 🗌 No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated. 29b. Signature and title of certifie

29c. License number
DU4395

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIEUE DOBERMAN, MO WTOWSONTOWN BLVD, TOWSON, MD 21204 555 31. Date filed (Month, Day, Year)

State Registrar



ORIGINAL

DHMH 17 Rev 1/2001

To the Hospital within 24 hours a To the Funeral L

completely

**Physician** /Medical

Examiner

Funeral

Director

29a. Certifier (Check only one)

29b. Signature and title of partifier

Padma

31. Date filed (Month, Day,

Director

Funeral

Be Completed by

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Examiner

For		State Of Mir	aryianu / L	Jopaili	ment of Health a	ana Me	ntal Hygier	1e	
<ul><li>State Registrar</li></ul>			,		icate of Death		Reg. N	000	9 18721
	e (First, Middle, Las	st) LL A	11			2.	. Date of Death	<u> </u>	3. Time of Death
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Washir	ng Have	ntist Ho	Sp; tal	To	akoma la	RK1/	UD .	MON	TROMERY (
5. Social Security N		ex 7. Age			Under 1 Year If Under 2 onths Days Hours		(Month, Day, Yea		Birthplace (State or Foreign Country)
084-18-(	3007	X .	85	110.		N	lov 10, 1	923   N	Newark, NJ
10a. State	10b. County		10c. City, Town	n or Locatio	on				10d. Inside City Limits
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10e. Street and Nur		J	JveI		0f. Zip Code		10g. (	Citizen of What	Country?
321 Univ	ersity B	lvd.West A	pt. #33	6	20901			USA	
11. Marital Status	<u> </u>	12. Was Decedent 8		13. Was	Decedent of Hispanic Orig s, specify Cuban, Mexican,	gin? (Specif	fv Yes or No-	14. Race - A	American Indian,
	ied 2□ Married	Armed Forces? 1 ☐ Yes 2 X N If Yes Give	10		s, specify Cuban, Mexican, Yes 2 <b>X</b> □No <i>Specify:</i>		an, ett.)		White, etc.
3 <b>X</b> Widowed	4 Divorced	If Yes, Give Year or Dates:			zpecify:				White
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Elementary/Seco	ondary (0-12)	College (1-4or 5		life. DO N	NOT use retired)	9	_	01404	16
	(First Middle Last)			Secre		r'e Nem - /-	First, Middle, Maide	eligiou en Surname)	19
17. Father's Name Michael	(First, Middle, Last) Horan						First, Middle, Maide :h Morgan		
		Time Pri-"		B.8 = 131					to Zin Code )
	ame/Relationship (7	Type. Print) (Son)		•	ddress (Street and Number				
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4 □ Donation	5 ☐ Other (Specify	y)	Li Nat	ional	Comptors	. 10/00		-	1
∠1. Signature of Fu	uneral Service Licen					5/9/09	Pi	nelawn,	, NY
X	un Br	indla		22. Na Fra	ame and Address of Facility nklin Funera New Hyde Par	y 1 Hom	ne		
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112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

/Medical Examiner

Medical Certification: To Be Completed by Physician/Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit After this certificate has been signed by the funeral director, page 2 should be detached to

> State Registrar



and manner stated

Rumamilla

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Eleanor Mae McDaniel June 2009 8:50 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 411 Green Hill Ave. Prince George Laurel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Aug. 7,1928 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🖾 F 199-24-2734 80 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, It a Medical Examination must be notified at MD 1 TxYes 2 □ No Director Prince George Laurel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 411 Green Hill Ave. 20707 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 ⊠No If Yes, Give Year or Dates: 1 Never Married 2K Married Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+1 Bank Teller Banking 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Emmitt Cole Leila Mae Marks ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James R. McDaniel/ Husband 411 Green Hill Ave., Laurel, MD 20707 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition June 9. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. View Cemetery 2009 Hopwood, PA 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. Kein' M01053 313 Talbott Ave., Laurel, MD 20707 (\$\frac{1}{2}\$a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a Alzheimer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulsease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transi Due to (or as a consequence of): physician a the burial Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) ed by the a detached f Ö 9 Unknown cate has been signed by page 2 should be detach σ, Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ⋧ 1 ☐ Yes 2XCXNo 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed The certificate ! 1 ∐Yes 2 ⊠No 1 ☐ Yes 2 🗷 No Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 Tes 2. No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending **X**Natural 5 ☐ Pending investigation after death. 2 ☐ Accident 1 ☐ Yes 2 ☐ No the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled To the Hospital 29a, Certifie 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner statege: 29d. Date signed (Month, Day, Year) 29b. Signature and title-of-certifier 29c. License number June 4, 2009 D53235 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13635 Baltimore Avenue, Laurel, MD 20707 MD, Darryl Α. Hill, 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year Alexander 05 x7 200° 51a /Medical 4a. Facility Name (If not institution, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Himore Baltimore If Under 24 Hrs 8. Date of Birth (Month, Day, May 27, 9. Birthplace (State or Foreign **Funeral** <sup>Year)</sup> 2009 Months Days 3Hours Maryland **Director** Infant Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, for Wedical Examination and injury or other traumatic event, for Wedical Examination and injury or other traumatic event, for Wedical Examination. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No MD Prince Georges Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8830 Hunting Lane 20708 Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 払 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Infant College (1-4or 5+) Infant Infant Infant 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) ၉ Timeka Gaskins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) University of Maryland 22 South Greene Street; Baltimore, Maryland 21201 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 Nother (Specify) in State 21. Signature of Funeral Service Licensee Ron S Wade 22, Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, Maryland 21201 se, of mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. rt 1. Enter the dise se slock, or heart failu e. L Approximate Interval Between Onset and Death Immedi te Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it my leading to investigate cause. Enter Underlying Cause (Disease or injury that initiated event) as the conditions of the c Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical his certificate has been signed by the attending p director, page 2 should be detached for use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 ☐ No 1 ☐ Yes 1 X Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and P.0. of Vital Records, Division

21215-0036

Baltimore, Maryland

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Greene St Baltimore MDZIZOI 22

31. Date filed (Month, Day, State

32. Registrar's Signature JUN 1 1 2009

Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20a-c&22 Per FH G893 //01/09 JH
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 358 AM 2009 Baby Girl Miles 6 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Roseclate Baltimore FRANKLIN SQUARE HOSPITAL CENTER If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 5 Months 1 ☐ M 2 🛱 F Maryland infant June 1, 2009 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show "natural", or items 23a or 28a-f shov edical Examiner must be notified at 1 ☐ Yes 2√7 No MD Baltimore Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 231 S. Eastern Court 21221 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No altimore, Maryland 21215-0036 white Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than . Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withinent of Health and Mental Hygiene.
Int: If item 27 is marked other than infant infant infant infant traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Justin Coleman Jevon Miles ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau 9000 Franklin Square Drive Rosedale, MD Franklin Square Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition "3urial 2 ☐ Cremation 3 ☐ Removal from State State (Specify) In State 4 Donation Sirector 21. Signature of Euneral Service S. Warde 22. Name and Address of Facilit State Anatomy Poard 655 West Baltimore Street 23a. Part 1. Enter the distriction of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Preterm Labor /Medical Due to (or as a consequence of): Examiner Infection maternal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. I been signed by the should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has to lirector, page 2 s autopsy performed? 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ this 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide within 24 hours a

To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certifier 29c. License number 6/2/09 RESOOOO

State Registrar

DHMH 17 Rev 1/2001

JUN 1 1 2009

DRRAYMonda 31. Date filed (Month, Day, Year)

9000 FRANKLIN Square DR Balto md 21237 rBour 32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a Perstate of Mary Panto / 92 partment of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** William McKewin 2009 2:30A M Shelton June /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Hammonds Lane Center Brooklyn Park If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) <sup>Year)</sup> 1917 **Funeral** Months Days Hours Min. 1 X M 2 □ F Sept. 201-10-4083 91 Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a, State 1 ☐ Yes 2 No ed other than "natural", or items 23a or 28a-f sl event, the Medical Examiner must be notified Director Linthicum MD Anne Arundel 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21090 U.S.A. 541 Pritchard Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 12 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or iten any injury or other traumatic event, the Medical Examine once. 1 Never Married Married 1 ☐ Yes 2 No White Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Grocery Store Bakery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vincent Richard McKewin Grace Darling Smith ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relation of the Wife Mrs. Thuryle Virinia McKewin/ 541 Pritchard Drive Linthicum MD 21090 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) June 12. 20a Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 2009 Sykeville , MD Lake View Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical Due to for as a consequence Examiner Ecquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria by Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 - Ectopic pregnancy Year Month Day 5 Other (specify) been signed by the should be detached I □Yes 2 □ No 9 HInknown Part 1. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably → Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 sl autopsy performed? Yes 2 No 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

the Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, 1 24 hours after death.
In Funeral Director: A pletely filled in by the full

death with the

Baltimore, Maryland 21215-0036

within 2.

State Registrar person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of

845

and manner stated.

DAICWOOD RD Suite IN

29b. Signature and title of certifier

Registra

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Norkas Month CAIG 30 03: 20 AM 1 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Woodside Center Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) FEb 26, 1965 Birthplace (State or Foreign Country) 1**X** M 2□ F Months Days Hours Indiana 312-76-0796 44 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No MD Germantown Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20531 Shadyside Way 20874 USA 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) 12 graphic artist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dennis Norkus Barbara Ann Norkus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Norkus/spouse 20531 Shadyside Way Germantown, MD 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ✓ Donation 5 ☐ Other (Specify) 21. Signature of Fuseral Sen ice Licensee Ronald S. Wade State Anatomy Board 655 W. Baltimore Street Director

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

Examiner

Director

Funeral

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Be Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be matter and once.

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the Internal director, page 2 should be detached for use as the burial-transit attending physician and I for use as the burial-transit ed by the a detached f

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JUN 1 1 2009

Columbia Road

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W.W

32. Registrar's Signature

Division of Vital Records, P.O. Box 68760,

annin	1/1/		more, MD 212		
23a. Part 1 Enter the disease, or form shock or heart failure. List only	Dications that caused the decone cause on each line.	ath. Do not enter the m	ode of dying, such as cardi	ac or respiratory arrest,	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a Multiple	Sclerosis			19418
, seeming in dealin,	Due to	or as a consequence o	of):		
Sequentially list conditions,	b. — Due to	or as a consequence o	T).		
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	•	,	•		
that initiated events resulting in death) Last	Due to (	or as a consequence o	f):		
	d				
				1 ☐ Yes 2 No  24a. Was an autopsy performed?	3 Probably 4 Unknown  24b. Were autopsy findings available prior to
				1⊡ Yes 2 <b>)</b> ŽÎNo	completion of cause of death?
25. Was case referred to medical examiner?			26. Place of De	eath (Check only one)	J
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□ I	OOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Oth	er (Specify)
27. Manner of Death 1 Natural 5 ☐ Pending 2 Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurr	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Spec	ome, farm, street, factory)	ory, office	28f. Location (Street and Numb City or Town, State)	er or Rural Route Number,
29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exem	rsicien: To the best of my known iner: On the basis of examination and manner stated.	owledge, death occurre ation and/or investigation	d at the time, date and place on, in my opinion, death occ	e, end due to the cause(s) and ma urred at the time, date and place, a	anner as stated. and due to the cause(s)
29b. Signature and title of certifier			9c License number	29d Date signer	d (Month Day Year)

29c. License number

, Saite 334; WAShington, DC 20009

20004814

29d. Date signed (Month, Day, Year)

June 03, 2009

**DHMH 16 Rev 6/95** 

State

Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** June 8, 11:20 A M Thelma Μ. 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 27 Northampton Road Timonium Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 😡 F 95 Director 219-12-6457 February 1, 1914 Maryland Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10h. County 10c. City, Town or Location ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hydiene. The strict is marked other than "natural", or items 23a or items 1 are 1 ments to 1 ments the 1 ments the 1 ments 27 Northampton Road 21093 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 KINo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify \$ Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clara Geisel Clay Leroy Lambdin ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 27 Northampton Road, Timonium, Maryland 21093 Denise Nix / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Memorial Gardens 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) June 12, 2009 Timonium, Maryland 21. Signature of Funeral Service Licen e <sup>22. Name and Address of Facility</sup> Towson, Maryland 21204 Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or a a consequence of) Examiner Steno Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 Yes PNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 1 □ Yes 2 🗆 No 2 Accident 6 □ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division of Vital Records, P.O. Box 68760, To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached 24 hours after death Pruneral Director: within 2 To the 1 the 0

Keuin Schendel 9114

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RD., Suite 300 BAGO NO 21237 Philadelphia 31. Date filed (Month, Day, Year,

State Registrar 32. Registrar's Signature

and manner stated.

Schuld

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Yea 2009 Jeannette M. O'Brein June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Square Balt osedal If Under Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, ) Sept 16, 6. Set 7. Age (In **Funeral** Year) Days Months 1 ☐ M 2 😾 F Hours 62 Director 1946 801-35-0917 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits iges 1 and 2 should be filed within 72 hours after death with the Marylar nt of Health and Mental Hygiene. If item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examination and the modified at MD Baltimore Director Rosedale 1 □Yes 2√ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6600 Ridge Road 21237 USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. 1 Never Married 2 Married 1 □Yes 27 No Specify. $\mathcal{J}$ eanethe $\mathcal{J}$ altimore, Maryland 21215-0036 Specify: white 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) homemaker own home unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roseanna Keene/daughter 7506 Eagle Rock Court #F Rosedale, MD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ⚠ Other (Specify) in State 21. Signature of Feneral Servic Licensee No. 1. Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** inebrovasi P /Medical Que to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami tension and burial-trar u t (or as a consequence of): P.O. Box 68760, attending physician for use as the buria the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the a page 2 should be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this in by the funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of After 1 Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 🗀 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, Hospital or Attending Physician: within 24 hours after deatt
To the Funeral Director:
completely filled in by the the

> State Registrar

DHMH 17 Rev 1/2001

ca

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DF-SHRIVATSA NADIGER

Franklin

M.D

9000

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

License number

29d. Date signed (Month, Day, Year)

01/2009

Federick Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Sune 6, au-**Physician** William Frederick Peterson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 1.29 8. Date of Birth (Month, Day, Dec 30, If Under 1 Year \_ If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** 1944 Days Min Months Hours Maryland 1 🕅 M 2 🗆 F Director 214-44-4474 Usual Residence of Decedent Name Known To Physician: Referent Baltimore, Maryland 21215-0036 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show other traumatic event, the Medical Examinar Lust be notified at Director 1 ☐ Yes 2 ☑ No Perry Point MD Cecil 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ŏ 21902 USA items 23a Perry Point Veterans Hospital by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 ☐ Married "natural", or If Yes, Give Year or Dates: 1 ☐ Yes 2√ No Specify. Specify: white 69-71 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) plumber unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Florence Hahn ပ Charles Peterson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Heatth ar
Important: If item 27 is
any Injury or other trau 21154 4702 Rocks Road Street, MD Charlene Buecker/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State in state 4 ☐ Donation 5 🖾 Other (Specify) 21. Signature of Emeral Service Licenses Ronald Wade, Director State Anatomy Board 655 W. Baltimore, MD 21201

23a. Part1 Enter the diseas, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, rheart failure. List only one cause on each line. State Anatomy Board 655 W. Baltimore Street Approximate
Interval Between
Onset and Death Immediate Chuse (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and burial-tran certificate be execu Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the as nse yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) P.0. the 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an page 2 s autopsy performed? certificate Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director; After the completely filled in by the funera 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 5 Pending 1 ☐Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) VA Many land Health Core System 482. Registrar's Signa Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20a-c#22perFH, G892, 6/26/09, WS
State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar		State of M	aryland		artment of F rtificate of				jiene eg. No. 2	009	187	32
	Physici		1. Decedent's Name	(First, Middle, La	st)					2	. Date of Dea Month	th Day	Year	3. Time of Dea	
	/Medic		Arthur	Palmer							une 4,	2009		10:22	AM
	Examin	er			re street and number)			4b. City, Town, c					nty of Death		
			Washing 5. Social Security Nu		ntist Hosp	oital e (In yrs. la	et hirthday)	Takon If Under 1 Year			. Date of Birth		tgomer	y lace (State or Fo	reian
	Funeral Director		578-38-52	78	1 <b>X</b> M 2□ F	79	Yrs.	Months Days	Hours	o Min	eb 24,	(Vear)	Cour	ington I	
	and and		Usual Residence of I	10b. County		10c. City,	Town or Lo	cation					1	0d. Inside City Li	mits
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	r 28a	Director	10e. Street and Num	nber			Hab!	10f. Zip Code			1	l0g. Citizen o	of What Cour	itry?	
	h with	a D	1300 6th	Street	#1025			20	0001				USA		
336	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ent, its M. dical Examination matter matter	by Funeral	11. Marital Status 1 ☐ Never Marrie 3 ☐ Widowed 4		12. Was Decedent Armed Forces? 1 □ Yes 2 ☑ If Yes, Give Year or Dates:			Was Decedent of H If Yes, specify Cub I □ Yes 2X No			fy Yes or No- can, etc.)	В	Race - Americ Black, White, cify: bla	etc.	
2-0	72 hours "natural"; deal Exe	sted	(Speci	15. Decedent's E	ducation		16a. Dece	dent's Usual Occup	oation	nost of working		16b. Kind of	f Business/Inc	dustry	
21215-0036	I within 72 ho giene. r than "natui in Wedler!	Completed	Elementary/Secon		College (1-4or	5+)		kind of work done DO NOT use retire		iosi oi working		1 1 .	<b>4.1</b>		
2	e filed withir al Hygiene. other than vent, the M	ပိ	17. Father's Name (/	First Middle Last	0		sec	urity gu unk	1	other's Name (	First Middle		thcare	11	ınk
and	d be f ental   ked of c eve	o Be	17. Faulers (value (r	not, whole, Last	,			ulik	10.1110	and or tame (			,	u	.IIK
Maryland	es 1 and 2 should be filed v of Health and Mental Hygir if item 27 is marked other r other traumatic event,	ျ	19a. Informant's Na	me/Relationship	(Type. Print)		19b. Mailir	ng Address (Street	a <i>nd Nu</i> n	nber or Rural I	Route Numbe	r, City or Tov	wn, State, Zip	Code)	
Ž	and 2 saith a		Veronne	Palmer/s	pouse		1300	6th Str	eet i	#1025 W	Jashing	ton, I	DC 20	001	
ore	es 1 s of He fitem		20a. Method of Disp		Removal from State	20b. Pla	ace of Dispo metery, crer	sition (Name of natory or other pla	ce)	Dat	е	20c. Locatio	on - City or To	wn, State	
<u>Ĕ</u>	Page ment ant: It				fy) <del>in state</del>	- Rive	erdale	Pk. Crem	atory	6/11/	/2009 I	Riverd	ale, M	d.	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other trau		21. Signature of Entr	neral Service Uice	Wade Dir	ector	38	2. Name and Address	t l	diwAusti Board N.W. Wa	n Roys shingt	on D.	meral 200	Home, 1 lT	nc
			23a. Part 1. Enter th	e disease, or com	plications that caused one cause on each li	d the death.				as cardiac or	respiratory an	rest,		Approximate Interval Betwee	n
	Physician /Medical		Immediate Cause (F disease or condition resulting in death)	Final	a	Se	bsi	5						Onset and Deat	h ——
T	Examiner				Due to (or as	CV US		she c	erd	ievas	calan	dise	in		
	D .±	iner	Sequentially list con if any, leading to immoduse. Enter Under Cause (Disease or it that initiated events	ditions, nediate lying	Due to (or as	a conseque	ence of):	ohic C			<i>[</i> *	7,0			
	ecute and -trans	Examiner	Cause (Disease or in that initiated events resulting in death) L	njury ast	c. ALL	Le.		ocard	12	10/	arch	in			
68760,	ficate be executed physician and s the burial-transit		, , , , , , , , , , , , , , , , , , ,	·	Due to (or as	a conseque	erice oly.								
387		edicat		•	d										
P.O. Box	Attending Physician: The law requires that the death certificate be executed rideath. r death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent in the past 12 r 1 □ Yes 2 □ 9 □ Unknown	months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	☐ Ectopic pregnand ☐ Other (specify) _				-	Date of deliv Month	ery Day Yea	r
	v requires that the d been signed by the should be detached	þ	Part II. Other signifi	cant conditions	contributing to death b	ut not result	ting in the u	nderlying cause gi	en in Pa	rt I.			-	he cause of death	
ord	requir	sted													
Division of Vital Records,	ding Physiclan: The law n. After this certificate has b funeral director, page 2 si	Completed									24a. Was a autop perfor 1 □Yes	sy med? 2 No	tb. Were auto prior to co death? 1 ☐ Yes	ppsy findings avai mpletion of caus 2 □No	lable e of
<b>Xit</b>	siclar certil recto	Be	25. Was case referre examiner?  1 ☐ Yes 2 ☐ 1		Hospital:	1		Ott	or:	ace of Death (					
of	Phys er this eral dir	i:To	27. Manner of Death		28a. Date of Inju	iry 2	28b. Time o	IT 3 LI DOA	4 🗆	Nursing Home	d. Describe h			TY)	
on	nding Fith. Th. After the funer	tior	1 ☑ Natural 2 ☐ Accident	5 ☐ Pending investigatio	(Month, Da	ıy, Year)	Injury		k? ]Yes 2	□No					
Divis	= £ €	Certification: To	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	200. Flace of III	ury - At hon c. (Specify)	ne, farm, str	eet, factory, office		28	f. Location (S City or Tow	Street and Nu n, State)	ımber or Rur	al Route Number	
(E)	To the Hospital of within 24 hours af To the Funeral D completely filled i	Medical C			hysician: To the best miner: On the basis o and manner st	of examination									
(0)	<b>То th</b> within <b>То th</b> compl	Me	29b. Signature and t	title of certifier				29c. Licen					gned (Month,		
				1	M, D	D		00	06	0100		00	5-03	- 9	
			30. Name and addre	ess of person who	completed cause of o	leath (Item:	23a) (Type, ]	Print) . Th	111	minn	Shop	Aug	102	+ 9 + 3	
	` Sta Registr		31. Date filed (Month	h, Day, Year) 1112009	32. Regist	ar's Signatu	par	le)							

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Monte **Physician** PUSIN HERMAN 6 S/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 830 W. 40TH STREET N/A BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 3ex 1.XXM 2.□F Hours Days 03/24/1914 95 MN 473-07-6411 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State r 28a-f show notified at 1 XYes 2 □ No Funeral Director BALTIMORE MD N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ms 23a or 3 830 W. 40TH STREET 21211 of Health and Mental Hygiene. Item 27 is marked other than "natural", or items; other traumatic event, the Medical Examiner mu Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗱 No WHITE Specify: Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working VICED PRESIDENT OF ENGINEERING AND RESEARCH 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) AERONAUTICAL College (1-4or 5+) Elementary/Secondary (0-12) ENGINEERING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **PUSIN** MORRIS **ESTHER** BERNSTEIN 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If Item 27 Is any Injury or other trau MICHAEL PUSIN / SON 3416 WOODVALLEY DRIVE, BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BETH EL MEMORIAL PARK 06/10/2009 RANDALLSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CongestivE FAILURE nmediate Cause (Final heart Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions it any loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner ig physician and as the burial-transit Due to (or as a consequence of) use IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Day Year 5 ☐ Other (specify) ate has been signed by the a page 2 should be detached 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by errension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ Inpatient \_ 2 No မ 1 ☐ Yes 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident

or Attending Physician: The law requires that the death certificate be executed Box 68760, Division or Vital Records, P.O. within 24 hours after death.

To the Funeral Director: A completely filled in by the fi To the Hospital

altimore, Maryland 21215-0036

6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only

29d. Date signed (Month, Day, Year)

MARYLAND

State Registrar

Medical

29b. Signature and title of certifier

830 Don m.D. PTY 31. Date filed (Month, Day, Year)

JUN 1 1 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

D35102

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** amos Kobersi F. 10 2009 01:10AM JUNE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Medical Saint Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day) 7. Age (In yrs. last birthday) Funeral Days 578.60.0390 1 **X**M 2□ F 0710 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show in than "natural", or items 23a or 28a-f show the Worldal Exprine must be notified at Pikesville MD 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 Sudbrook permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Modeal Expriner reasts once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Kestaurant Cook 2th arade 17. Father's Name (First, Middle, Last) Will 18. Mother's Name (First, Middle, Maiden Surname) Be Kosa Mael Kobersor ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7425 Sudbrook Road Battimore MD 21208 x00maría Jawahir tnend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 109 Greenmount 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses C. Greens Faneral SIS Iday Stown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** GASTROINTESTINAL BLEED /Medical Due to (or as a consequence of): Examiner PULMONARY EMBOLISM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and burial-transit CIRRHOSIS OF LIVER Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the for use a 23c. if yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) □Yes 2□No ned by the detached t Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CORONARY ARTERY DISEASE 2 No 3 Probably 4 Unknown Completed peen 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of has certificate 2 No Division of Vital 1 🔲 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only on Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No pital: 1 Inpatient 2 ER/Outpatient 3 DOA

28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury
Injury
28c Certification: To this After this funeral of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident death. 1 ☐ Yes 2 ☐ No hin 24 hours after death the Funeral Director: the Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical npletely (Check only one) within 7 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 D52096 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

OSLER DRIVE

TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year) 32. Ogicirar's Signature

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Dav Year Leo Joseph Ritter /Medical June 9 2009 10:00 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Locetion of Death 4c. County of Deeth Examiner 719 Maiden Choice Lane BR540 Catonsville Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Months Days 1 X M 2 □ F 88 Yrs. Director 215-14-5867 1920 Maryland Nov. Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "neturel", or items 23e or 28a-f sho Director 1 ☐ Yes 2 No Maryland Baltimore Catonsville 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 719 Maiden Choice Lane BR540 21228 USA 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🖾 No Completed by Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Architect Commercial Buildings 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should I Lawrence B. Ritter Amy E. Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any Injury or other trau Glenice Ritter Wife 719 Maiden Choice Lane BR540; Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-12-09 Frederick, Maryland Mt. Olivet Cemetery 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signaulie of Funeral Service Lickns 1630 Edmondson Avenue; Catonsville, MD 21228 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical cancer Examiner Due to (or es e consequence of) Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): Part II. Other significent conditione contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of deeth? aperlyni Š 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 2 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24a. Was en eutopsy performed? 22 No 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: ours after death.

erel Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Medicai Certification: To 1 ☐ Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1- Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Hospital 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hou

To the Funer

completely fil 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) weren my

State Registrar

JUN 1 1 2009

31. Date filed (Month, Day, Year)

32. Registrer's Signature

**DHMH 16 Rev 6/95** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2009 12:35 a<sup>M</sup> Harry Albert Richardson, Sr. June 6, 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince George Laurel Regional Hospital Laurel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 19, 1917 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 1 X M 2 □ F 91 229-09-2348 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Nes 2 No Prince George Laurel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 1013 Seventh St. 20707 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc 1⊠Yes 2□No 1954-1 Never Married 2 Married white 1 ☐ Yes 2 🔼 No Specify: If Yes, Give Year or Dates: Specify: 74 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Army Staff Sgt. 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Moncie Richardson Mintie Halsey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11902 Queen St., Fulton, MD 20759 Mary Ann Souder/ Daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 10, June 1 Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 2009 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee KenSkle 313 Talbott Ave., Laurel, MD 20707 M01053 Approximate 23a. Can't 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory Failure Due to (or as a consequence of) Congestive Heart Failure Sequentially list conditions, it is a sequentially list conditions, it is a sequential to a se Due to for as a consequence of C.O.P.D. Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery

**Physician** /Medical **Examiner** 

permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygiens important: if Item 27 is marked other the any Injury or other traumatic event, that Once.

**Physician** 

/Medical

Examiner

10a State

**Funeral** 

**Director** 

28a-f show

Director

Funeral

þ

Completed

Be

ဂ

r than "natural", or Items 23a or 28a-f show

72 hours after

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

Examiner

sician and burial-trans attending physician for use as the burial ned by the ate has been signed by page 2 should be detack Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica filled in by the funeral director,

24 hours a To the I within 2

Physician/Medical 23b. Was decedent pregnant in the past 12 months? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Completed 25. Was case referred to medical examiner? Be Certification: To 27, Manner of Death 29a. Certifier Medical

29b. Signature and he

9 Unknown

28a. Date of Injury (Month, Day, Year)

and manner stated.

29c. License number

D55861

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

3 Ectopic pregnancy

5 ☐ Other (specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

June 6, 2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Month

23e. Did tobacco use contribute to the cause of death?

24a. Was an performed

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

1 ☐ Yes 2 ☑ No

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 3x ☐x Probably 4 ☐ Unknown

Year

Day

Were autopsy findings available prior to completion of cause of

1 ☐ Yes 2 🔯 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

5 Pending investigation

6 ☐ Could not be

Laurel, Maryland Abdul Munim, M.D. 8379 Cherry Lane

31. Date filed (Month, Day, Year) State Registrar

1 ☐ Yes 2 ☐ No

9 Unknown

1 ☐ Yes 2 🔀 No

1 X Natural

2 Accident

3 Suicide

4 Homicide

. Registrar's Signature

1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month June **Physician** Year Geraldine Hardy Rodgers ſδ 9:35 PM 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Baltimore Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 19 9. Birthplace (State or Foreign Country)
Maryland 6. Sex 7. Age (In yrs. last birthday, **Funeral** 191<u>9</u> Months Days Hours 1 ☐ M 2 🗓 F 215-16-1304 Director 89 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show injury or other traumatic event, the Medical Examinary ust be notified at Completed by Funeral Director 1 ☐ Yes 2 X No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with to ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or; 6451 N. Charles St. 21212 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Bace - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3XWidowed 4 ☐ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond F. Hardy Marguerite Labarre 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy M. Rodgers/son 125 Charlesbrooke Rd. Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. New Cathedral Cemeter June 15,2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility

Mitchell-Wiedefeld Funeral Home, 21. Signature of Funeral Service Licenses of D. Mitchell 6500 York Rd. Baltimore, MD 23a. An 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ans disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed the hours after death. Funeral Director. After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit med. Due to (or as a consequence of) P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Hinknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐Yes 2 ☐No 2 Accident investigation 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 29a. Certifier Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2. tere and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 V LES M JUN 11 Date filed (Month, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. " 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2009 **Physician** June 9, 6:07 A Nancy Mary Rock /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson Pickersgill If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, NOV. 9, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex MaryTand Months Days <sup>7</sup>1913 1 ☐ M 2 🔀 F 215-18-6080 95 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Timonium Baltimore Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21093 123 Croftley Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 ☐ No Completed by 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Army Corp. of Engineers Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cooper Charles Minnick Harriett 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Timonium, Md. 21093 Croftley Road 123 Sheila J. Farrell / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Hilltop Service Corp. 6/10/09 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 1050 York Rd. 21. Signature of Funeral Service Licen-Ruck Towson Funeral Home, Inc. Towson, Md. 21204 ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final months disease or condition resulting in death) to (or as a consequence of): eoporosis with Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical þ Completed Be Certification: To

Examiner The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

g physician and

**Physician** 

/Medical

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		opic pregnancy er (specify)	23d. Date of delivery  Month Day Year
Part II. Other significant condition	ns contributing to death but not resulting in the underly	ying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown
			24a. Was an autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No
25. Was case referred to medical	I .	26. Place of Death	(Check onl. one
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	DOA Other: 4 Nursing Hom	ne 5 Residence 6 Other (Specify)
27. Manner of Death  1 Natural 5 Pending 2 Accident investiga		28c. Injury at Work?  1	8d. Describe how injury occurred
3 Suicide 4 Homicide 6 Could no determin		factory, office 2	8f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Certifying (Check only one) 2 Medical E	p Physician: To the best of my knowledge, death occ examiner: On the basis of examination and/or investi- and manner stated.	curred at the time, date and place, a igation, in my opinion, death occurre	and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause(s)
29b. Signature and title of certifier	10	29c. License number	29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

Medical

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUN 1 1 2009

2. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death \_Month Ye ar **Physician** 1:45 PM enala 2009 lune /Medical Facility Name (If not institution, give street and number) City, Town, or Location of Death County of Death Examiner Itmore Balton riew (ours If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD Social Security Number Sex 1 M 2 □ F 8. Date of Birth (Month, Day, Year) 05/03/1923 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 215-14-4482 86 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if Modical Exercited in the Facilied at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 X No **Funeral Director** MD BALTIMORE COCKEYSVILLE 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 13801 YORK ROAD, D-9 21030 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 XYes 2 ☐ If Yes, Give Year or Dates: 2 No NAVY 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify: WHITE <u>م</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ ATTORNEY LAW 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FRANK ROTHMAN ဂ္ MINNA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELIZABETH ROTHMAN / WIFE 13801 YORK ROAD, D-9, COCKEYSVILLE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State CARROLL CREMATION INC 06/10/2009 HAMPSTEAD, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a Jermina PHENUM disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** ration Sequentially list conditions, if any loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Unknown ty and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) □Yes 2□No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature, and title of certifier

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signatur

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Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs.	.,	If Under	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day	h v, Year)	9. Birth Cou	place (State or Foreign intry)
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permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service L	Litare	Mit		uneral 630 Ed	l Hon	me of dson	Cat	onsvill ue: Cat	le, Inc	ie, M	Witzke ID 21228
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To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2.	Medical (		g Physician: To the Examiner: On the t and man										
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7		30 Name and address of person v	vho completed caus	se of death (Iten	n 23a) (Type,				RJ	# 2	52,B	alkin	2009 nove, HD
Sta Registi		31. Date filed (Month, Day, Year)	000 2	se of death (Iten	iture de	de		INE	,	]*	, -	41.	
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			1 - For State Registrar	State of N	Maryland		artment of rtificate of		nd Mental Hyg	iene 00	9 18	3741
	Physici /Medi		1. Decedent's Name (First, Middle Stephen	e, Last) M		Sc	natz		2. Date of Deat Month		Year 7	Time of Death
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	Funeral Director		5. Social Security Number 218-78-0230	6. Sex 1 □ M 2 □ F	Age (In yrs. Ia 48	st birthday) Yrs.	If Under 1 Yea Months Days		Min. 8. Date of Birth (Month, Day, Feb. 19	Year) ,1961	9. Birthplace ( Country) Marylar	State or Foreign nd
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920	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "neturel", or items 23e or 28e-f show event, i'm Medical Exercitive funds for rediffical et	by Funeral Director	11. Marital Status  1 Never Married 2 Marr 3 Widowed 4 Divorced	If You Give	s? ⊒yNo		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☐xNo	ban, Mexican, F	n? (Specify Yes or No- Puerto Rican, etc.)	Black	- American Inc k, White, etc. white	lian,
21215-0036	within 72 ho ene. then "netur	Completed		t's Education st grade completed)  College (1-4c	or 5+)	(Give life.	dent's Usual Occu kind of work done DO NOT use retir	e during most o	working Facilitie	16b. Kind of Bus		
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	nd 2 shullth and 27 is m		19a. Informant's Name/Relations Evelyn Hoban	hip <i>(Type, Print)</i> wife					or Rural Route Number Millersvil			)
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.O. Box 68750	that the death extification by the attenting phy detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No		2 Fetal of dea	death 3	Ectopic pregnan Other (specify)	су	V *	23d. Date Mon	e of delivery oth Day	Year
α.	w requires that been signed b should be deta	þ	Part II. Other significant condition	ens contributing to death	but not result	Iting in the u	nderlying cause g	iven in Part I.	23e. Did to	pacco use contri	ibute to the cau	use of death?
al Reco		Completed							24a. Was a autops perform	med? d	Vere autopsy fir rior to completi eath? Yes 2	
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Division of Vital Records,	anding lath. or: After	ation: To	27. Manner of Death 1 □ Natural 5 □ Pendir 2 △ Accident investi	gation 05126	njury	28b. Time o	f 28c. Inj	4 🗀 Nurs	28d. Describe h			· ·
Divis	i Pitte	Certification:	3 Suicide 6 Could 4 Homicide determ	inod 286. Place of	Injury - At hon etc. <i>(Specify)</i>	me, farm, str	reet, factory, office		28f. Location (Si City or Town 320 Ar		or or Rural Rous	ite Number,
	B Hospitel 24 hours a B Funerel I etely filled	edical	29a. Certifier 1 Certifyir (Check only one) 2 Medical	ig Physicien: To the be Exeminer: On the basis and manner	of examination	vledge, deat on and/or in	h occurred at the vestigation, in my	time, date and popinion, death	place, and due to the c occurred at the time, d	ause(s) and mar ate and place, a	nner as stated, and due to the o	ause(s)
)	To the within 2 To the complex	Me	29b. Signatule and title of certifie	(m)				oo 6	2	9d. Date signed	1 (Month, Day, 2007)	Year)
_	12 v		30. Name and address of person ROFI ROY	who completed cause o	death (Item	23a) (Type,	Print)	x) )}	v-1615	n 8	h/nj-	e, m)
	Sta Registi		31. Date filed (Moeth, Day, Year	Server 32. Regi	strar's Signatu	Sove Contraction			,			, -

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2009 Year Gertrude Skopp June 12:00 P.M /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1 Smeton Place Unit 505 Towson Baltimore County 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Baltimore, MD. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) July 02,1923 **Funeral** 1□M 2∰F Months Days Hours Min. 85 217-14-0192 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinations to notified at Director Maryland 1 ☐ Yes 2 No Baltimore County Towson filed within 72 hours after death with the I Hygiene. 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1 Smeton Place Unit 505 United States 21204 Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 24∑ No þ Specify White 3 Midowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Broker Real Estate 7 Is marked other traumatic event, It permit. Pages 1 and 2 should be file Department of Health and Mental H Important: If item 27 Is marked oth any Injury or other traumatic event Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Adolph Zalowski Frances Brezinski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. John D. Skopp (Son) 2207 Aquilas Delight Fallston, Maryland 21047 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Parial 2 ☐ Cremation 3 ☐ Removal from State June 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. 2009 Timonium, Maryland 22. Name and Address of Facility eaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service Licenses sease, or complications llure. List only one cause 23a. Part 1. Enter the disea shock or heart fallure Immediate Cause (Fina or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death on each line **Physician** 4 hs disease or condition resulting in death) 0 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or do a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 physician Completed by Physician/Medical as 1 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year n signed by the a 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Residence 6 Other (Specify) After this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only within 2 To the

12 State 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

510

32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001 6-101

29c. License number

29d. Date signed (Month, Day, Year)

09-04185 Alfred Simms

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Criticate of Death  Registrar  Certificate of Death		J. No. 00	00 1071
Physic Medical Exam			. Date of Death	201	3 Time of Death
medical Exam	mie	Alfred Simms  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	Month May 26, 20	4c. County of Dear	1005 hrs
		401 East 25th Street Apt. 2N Baltimore		4c. County of Deal	
Funera			8. Date of Birth	(MM/DD/YYYY) 9. Bi	
Directo	(		Nov 19,	1941	ountraMaryland
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Maryland 28a-f show any d at once,	=	MD Baltimore			1 X Yes 2 No
Maryla 28a-f d at or	Director	10e. Street and Number 10f. Zip Code	100	g. Citizen of What Cou	Intry?
th the 23a or notifie	<u>=</u>			USA	
ath wi items	uneral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specific Yes, Specify Cuban, Mexican, Puerto Rice) 14. Marital Status 15. Was Decedent Ever in U.S. 16. If Yes, Specify Cuban, Mexican, Puerto Rice 17. If Yes, Specify Cuban, Mexican, Puerto Rice 18. Was Decedent Ever in U.S. 19. If Yes, Specify Cuban, Mexican, Puerto Rice 19. If Yes, Specify Cuban, Puerto Rice 19. I	ify Yes or No- can, etc.)	14. Race - Ame White, etc.	rican Indian, Black,
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	Raymond McCoy Esther S		aiden Sumame)	
21 Should and Me is ma	2	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Control of the Control of	al Route Numb		
mand 2 short earth and earth and tem 27 is traumatic		Rosalee Branch/sister 4003 Orchard Ridge B1  20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, D			
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygene, mark of Health and Mental Hygene, and inaturall, or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once,		1 Burial 2 Cremation 3 Removal from State crematory or other place)	Date	20c. Location - City of	Town, State
Baltimore, MD 21215-003 pernit. Pages I and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 is marked other tralmarty or other traumatite event, the Med		21. Signa up of Funeral Sec ce Licensee On d S. Wade, line tor  22. Name and Address of Facility State Anatomy Board			
in T ga		State Anatomy Board	655 W.	Baltimore	Street
Physician /Medical		2 a. Parl I. Enter the disease, or complications that caused the death. Do not enter the mole of dying, such as cardiac or refailule. List only one cause on each line.	spiratory arres	t, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate sause (Final disease or condition resulting in death)  Atherosclerotic Cardiovascular Disease  Due to (or as a consequence of):			Death
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	nine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (C):cause or kniver that Districts (C):cause or kniver that Dist			
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Box 687.  he death certific  the attending perfection of the perfe	ysic	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify) 9 Unknown			
chat the	by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ords, P.O.  w requires that th sbeen signed by should be detach	ted t	Renal disease	100	2 No 3 Prol	oably 4 🗹 Unknown
of Vital Records, ag Physician: The law require After this certificate has been si neral director, page 2 should b	Completed		24a. Was an autopsy	prior to	topsy findings available completion of cause of
tal Recition: The certificate ector, page		25 Wee area of suit to a visit	perform 1 <b>Y</b> Yes 2	ed? death? No 1 ✓ Ye	es 2 No
Vital ysician his cert directo	Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  26. Place of Death (Check only Death (Check		esidence 6 🗸 Othe	
ing Ph After t	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28c		w injury occurred	. Scerie
Sion vtfendi death. ctor: y the f	atio	2 Accident Investigation 1 Yes 2 No			
Division of Vital Records, P.O. Box 68' Hospital or Attending Physician: The law requires that the death certifi 4 hours after death. Funeral Director: After this certificate has been signed by the attending ely filled in by the funeral director, page 2 should be detached for use as	Certification:	determined	. Location (Street or Town, State		ral Route Number, City
Di Hospital 4 hours a Funeral I ely filled		4 Homicide (Specify)  29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due		\	
Division To the Hospian or Attend within 24 hours after death To the Funeral Director:	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated.	e time, date an	s) and manner as stat d place, and due to th	e cause(s)
FSFO	ž	29b. Signature and title of certifier 29c. License number	2	9d. Date signed (Mo.	nth, Day, Year)
		O.C.M.E.		May 27, 2009	
		30. Name and address of person who completed cause of death (Item 23a)  Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			
		31. Date filed (Month, Day, Year) 32. Registrar's Signature			
Regist	_	JUN 1 1 2009 Server B. Sparla			

DHMH 17 Rev 1/2001 OCME 2006

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician 2009 PM -Inn June /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** Baltimore City The Johns Hopkins Hospital 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🛣 M 2 🗆 F 69 1940 Washington DC 401-56-8759 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location show Examiner must be notified at 1 ☐ Yes 2 No Director MD Prince George's Bowie 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 20715 USA 3407 Memphis Lane items 23a Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 X Married Maryland 21215-0036 ō 1 ☐ Yes 2X No Specify: white þ Specify: Year or Dates: 158-85 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk permit. Pages 1 and 2 should be filed within 72 hr
Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natuu
any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Earle Tyler Shoup Mary Pearl Linn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary Shoup/spouse 3407 Memphis Lane Bowie, MD 20715 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State 4X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service S. Wade, State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate shock. Onset and Death Immediate Case (Final **Physician** disease or condition resulting in death) ym phonic /Medical Due to (or as a o nsequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause and the cause (Disease or injury that initiated events Due to (or as a consequence of) attending physician and I for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav signed by the atter in the past 12 months? 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ pital or Attending Physician: The law requires thours after death.

eral Director: After this certificate has been signer filled in by the funeral director, page 2 should be a 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No 2 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 X Natural 1 🗌 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined e Hospital 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated. To the I vithin 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Res-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 NILANJAN GHOSH 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 1/200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 0920 NANCIE SHORTIT 04 2000 06 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTIMORE, MD UNIU 9 MARYLAND MEDICAL CTR If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Hours Min. June 1, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number 6. Sex **Funeral** Maryland 1 □ M 2 🗓 F 62 **Director** 217**-**52**-**6331 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Item March all Examiner must be notified at appres. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1√ Yes 2 No by Funeral Director Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21223 613 S. Payson Street . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) healthcare nursing assistant 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gertrude Harmen Francis Elliott Winstead မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zig Code) 613 S. Payson Street Baltimore, MD 21223 19a. Informant's Name/Relationship (Type. Print) Richard Shortt/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4∭Donation 5 ☐Other (Specify) 21. Signature of Funeral Services State and decomy aboard 655 W. Baltimroe Street cen wade Director 21201 Baltimore, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate C use (Final disease or condition resulting in death) Physician SEPTICEMIA /Medical Due to (or as a consequence of): Examiner vect) ENTEROCOCCA ENDO CARDITY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physlcian: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has I rector, page 2 s autopsy performed? 1 □ Yes 2 No 1 ☐ Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

State Registrar 29b. Signature and title of certifier

5 THOUS 31. Date filed (Month, Day, Year)

JUN 1 1 2009 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

MD

29c. License number

MEDICAL

NP1 11040ES448

CENTER

29d. Date signed (Month, Day, Year)

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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death June 8, <sup>Day</sup> 2009 Physician Tate 6:47 AMM Julia Ray Lee /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Southern Maryland Hospital Center Clinton 9. Birthplace (State or Foreign Country)
Akom, AL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Sept 29 **Funeral** Year) 1949 Days Hours 052-42-3974 59 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show 1 X Yes 2 □ No Director Prince George's Temple Hills 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7116 Karen Anne Drive 20748 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: \$ Black. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any injury or other traumatic event, It. M. disporte. Elementary/Secondary (0-12) College (1-4or 5+) Electric Meter Reader 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Oster Ray Leola Jackson ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20748 Melissa Tate Motley 7116 Karen Anne Drive Temple Hills, MD (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Erie Cemetery 6/15/09 Erie, PA 22. Name and Address of Facility
Law Funeral Home 21. Signature of Funeral Service Licenses bush 2926 Pine Avenue Erie, PA Approximate Interval Between Onset and Death 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ULMONARY EMBOLISM /Medical Due to (or as a consequence of): **Examiner** THROMBOSIS VENOUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be execute sician and burial-trans Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) P.O. □Yes 2 No detached 9 Unknown 9 Unknown á signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ★hknown Completed PERCHOLESTE DOLEMIA 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an page 2 s has certificate 1 □ Yes 2 completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated. within 2 the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Wellie FOU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Ke, Upper Marthoro T 628 Marlboro 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #5&18 Pegtatelopea?yland?69partinent of Health and Mental Hygiene

			1 - State Registrar			•		Cer	tificate	of L	Death			Reg. N	<u>.</u> 201	) )	lö	141
	Physicia	20	1. Decedent's Name	(First, Middle	e, Last)								2. Date of Do	D	av Ye	ar	3. Time o	
	/Medic		Caro1	L. Tuc	ker								May 25	5, 2	009		8:52	РМ М
1	Examin	er	4a. Facility Name (If			ımber)			4b. City, To			of Death			c. County of [			
				h Aven		1 7 4 - 11-	14 6 5-4	(	Balt If Under 1		ore If Under	24 Uro 1	0 D-t(D		Baltim		la == /04=4=	
H	Funeral Director		5. Social Security Nu 218-62-2 218-62-2	2759	6. Sex 1 □ M 2 💢 F	7. Age (In	yrs. last birti 42	rs.		Days	Hours	Min.	8. Date of Bi June I	ay, Year	966 Ma	Coun	ace (State try) and	or Foreign
	and w		Usual Residence of 10a. State	Decedent 10b. County		100	c. City, Town	or Loc	ation							10	d. Inside (	City Limits
	Maryli f sho	ō	MD	Balti	more				more									s 2√ No
	the 28a	Director	10e. Street and Num						10f. Zip Co	ode				10g. C	itizen of Wha	t Coun		
	be flied within 72 hours after death with the Maryland Hydjene.  d other than "natural", or items 23a or 28a-f show event, the lifethed Evenings and the motified at		726 5th	Avenu						122					USA			
	item item	Funeral	11. Marital Status  1  Never Marrie	od OM same	12. Was Dec	edent Ever orces? 2 XNo	in U.S.	13. W	/as Deceden Yes, specify	Cuba	n, Mexicar	igin? (Spe n, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - A Black, V			
9500-61212	irs aff	by F	3 ☐ Widowed 4		If Yes, G	ive		1	□Yes 2¶	No	Specify:				Specify:	whi	te	
Ş	2 hou	ted	(0,000)	15. Decedent	's Education		16a.	Deced	ent's Usual C	Occupa	ation			16b.	Kind of Busin	ess/Ind	lustry	unk
Z	thin 7	Completed	Elementary/Secon		t grade completed	1-4or 5+)			ind of work of NOT use									
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yland	be filed valued be of the vector of the vect	Be	17. Father's Name (						un	HE	18. Mothe	er's Name	(First, Middle	e, Maide	n Surname)			
3	should be nd Menta marked imatic ev	ပ္		t H. Y									ad Ann					
, Ma	ss 1 and 2 sh of Health and item 27 is n r other traun		19a. Informant's Na Frank Tu										re, MD		or Town, Sta 227	ite, Zip	Code)	_
saitimore,	Pages 1 ant of He ent of He rt; If iten ry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ 4 ☑ Donation	Cremation	3 Removal from		0b. Place of cemetery	Dispos v, crem	ition (Name atory or othe	of er place	e)	C	Date	20c. l	Location - City	y or To	wn, State	
Dalt	permit. Pages 1 and 2 should by Department of Health and Menta Important; If item 27 is marked any injury or other traumatic evonce.		21. Sign ture 1 Fur			Wrect	or	Sta	Name and A	Addres	ss of Facilit	ty oard	655 W.	Bai	ltimor	e Si	treet	
			23a. Part 1. Enter th	o dispage or	complications that	caused the	doath Don	Ba:	ltimor	e,	MD 2	21201	roopiraton/	arract			Approxima	ite
			shock, or hear	t failure. List i	only one cause on	each line.											Interval Be Onset and	etween
F	Physician /Medical		disease or condition resulting in death)						10	11	154	AY	MOL	Α		0	h yea	ars
1	Examiner			1	Due to	(or as a co	nsequence o	1):										
	700	je.	Sequentially list concause. Enter Under Cause (Disease or in	ditions,	b. Due to	(or as a con	Sequence U	ŋ:										
	cuted nd ransit	Examin	Cause (Disease or in that initiated events	lying njury	C.													
, ,	eruncate be executed Jing physician and e as the burial-transit	Ex	resulting in death) La	ast	Due to	(or as a cor	nsequence o	f):										
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0	sician: The law requires man me deam certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	Physician	23b. Was decedent in the past 12 m	nonths?		birth 2 pnant at time	Fetal death		Ectopic preg		/			- 13	23d. Date o Month		ry Day	Year
5	the c by the ached	ıysi	1 ☐ Yes 2 🔀 9 ☐ Unknown	INO	9 □ Unk				(0,000									
,	s mar	by P	Part II. Other signific	cant conditio	ns contributing to o	leath but no	t resulting in	the un	derlying caus	se give	en in Part I		23e. Did	tobacco	use contribu	ite to th	e cause of	death?
ğ	quires	q pe											1 🗆	Yes	2 No 3[	☐ Prob	ably 4□	Unknown
necords,	aw re as bee	Completed											24a. Wa		24b. Wer	re auto	psy findings	s available
ř	ate ha	mo	-										auto peri	opsy formed? 2 <b>X</b> N	prio dea	th?	npletion of	cause of
ומו	ertifica	Be C	25. Was case referre	ed to medical					TIETE-	-	26. Place	e of Death	1 ∐Yes ∩ (Check only			103	2 110	
5	nysic his ce I direc	10 E	examiner? 1 ☐ Yes 2 💢 N	No	Hospital:	Inpatient	2 ER/Out	patient	3 □ DOA	Othe	er: 4 □ Nu	ursing Ho	me 5 Res	sidence	6 ☐Other (	(Specify	y)	
=	ng P	ü	27. Manner of Death  1 Natural	5 Pending	28a. Date (Moi	of Injury oth, Day, Yea	28b. Ti	ime of jury	28c	. Injury Work	y at		28d. Describe	how inj	ury occurred		-	_
VISIOII	tendleath.	cati	2 ☐ Accident 3 ☐ Suicide	investig 6 ☐ Could n	ation of be				М		Yes 2□	No						
	s after d	Certification:	4 ☐ Homicide	determi	nod   28e. Place	e of Injury - ling, etc. <i>(S</i> i	At home, fari pecify)	m, stre	et, factory, o	ffice		ļ	28f. Location City or To	(Street a wn, Sta	and Number o te)	or Rura	l Route Nu	m <i>ber</i> ,
1	To the nospital or steedars, within 24 hours after death,  To the Funeral Director. After this certificate hy completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one)	Certifying	g Physician: To the Examiner: On the and mar	e best of my basis of exa nner stated.	/ knowledge, mination and	death d/or inv	occurred at estigation, in	the tin	ne, date ar pinion, dea	nd place, ath occurr	and due to th red at the time	e cause e, date a	(s) and mann nd place, and	er as s I due to	tated. the cause	(s)
, c	vithin To th	Me	29b. Signature and ti	itle of certifier	(ola	MD					number	Zj		29d. D	ate signed (A	Month,	Day, Year)	
			30. Name and addre	1.00		-			rint)	•			0.0	4 0	11/2	. UL		_
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	Stat Registra			N 1 1 2	009 Sen	ve .	Signature	bar	las									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1 Per ME G893 7/21/09 III / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 1140 M 2 Jesse T. Thompson Jux Jesse R. Thompson 2000 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Burni IPA A34 0 nod If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. July 31, 1940 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 □ F Maryland 68 214-38-0727 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Marylan 10b. County ral", or items 23a or 28a-f show MD Anne Arundel Glen Burnie 1 ☐ Yes 2 No Director Street and Number 7849 Crilley Road #501 10f. Zip Code 10g. Citizen of What Country? 21061 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married timore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: white <u>م</u> 3 ☐ Widowed 4 X Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) truck driver transportation unk unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jesse P. Thompson Sr ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thompson/daughter 923 Princeton Terrace Glen Burnie, MD Carri 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 K Other (Specify) in state 21. Signature of Eunoral Service Cicensee

Ronald S. Wade Director

Acceptions that caused the death. 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Bal 23a. Part1. Enter the disease, if corrections that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause if each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition terioscleratic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. ed by the attending physician detached for use as the buria death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 ate has been sign page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 □ Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner?
1 X Yes 2 ☐ No Be 26. Place of Death (Check only one) 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 | Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 □Yes 2 □No 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NES Ja mo 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

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Jesse

State of Maryland / Department of Health and Mental Hygiene O O O

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Physician /Medica Examine
Examine
///

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Evarinat must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Sta

	1 - State Registrar	Certificate of Death						
an	1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year							
cal	Robert J. Thommen		41. O't. T	L continue of Donath	June 10,		1:30 A M	
ner	4a. Facility Name (If not institution, give street and number) 245 Rachel Circle		Forest If Under 1 Year	Location of Death Hill If Under 24 Hrs.		4c. County of Dea Harford	thplace (State or Foreign	
	5. Social Security Number 213-30-9173 6. Sex 1 M 2 F 7. Age (In yrs. lat. 75)		Months Days	Hours Min.	8. Date of Birth 10/29/1	933 Mar	y land	
	10a. State 10b. County 10c. City,	Town or Loca					10d. Inside City Limits	
ctor	MD Harford Fore	est Hil	11				1 ☐ Yes 2 ☐ No	
<b>Funeral Director</b>	10e. Street and Number 245 Rachel Circle		10f. Zip Code 21050			10g. Citizen of What Country?		
nera	11 Marital Status 12. Was Decedent Ever in U.S.	13. Wa	13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					
by Fu	1 Never Married 2 Married   Armed Forces? 1 Nayes 2 No If Yes, Give Korea		If Yes, specify Cuban, Mexican, Puerto Hican, etc.)  1 □ Yes 2 ☑ No Specify:			Black, White, etc.  Specify: White		
etec	15. Decedent's Education (Specify only highest grade completed)	(Give kii	nt's Usual Occup	during most of work	ina	6b. Kind of Business		
Be Completed by	Elementary/Secondary (0-12) College (14or 5+)	life. DC	life. DO NOT use retired) ce President			Atlantic Builder		
To Be (	17. Father's Name (First, Middle, Last)  Philip E. Thommen  18. Mother's Name (First, Middle, Maiden Surname)  Helen 0'Connell							
	19a. Informant's Name/Relationship (Type. Print)	9				City or Town, State,		
	Mary Thommen / Wife					, Marylan		
	20a. Method of Disposition  1  Burial 2  Cremetion 3  Removal from State 4  Donation 5  Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery  20c. Location - City or Town, State Baltimore, Maryland							
	21. Signature of Euneral Service Licensee  22. Name and Address of Facility Towson, Maryland 21204 Ruck Towson Funeral Home, Inc. 1050 York Road							
	23a. Part 1. Enter the disease, or complications that caused the death.	Do not enter	the mode of dyir	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between	
	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Renal Cell Carcinoma metastatic  2/2 year							
	resulting in death)  Due to (or as a consequence of):							
J.	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):							
ш	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C.							
Medical Examiner	resulting in death) Last  Due to (or as a consequence of):							
lical	d							
	IF FEMALE: 23c If yes, outcome of program							
Completed by Physician/	23c. If yes, outcome of pregnancy  23b. Was decedent pregnant in the past 12 months?  1						23d. Date of delivery  Month Day Year	
y Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?							
q pa	1   Yes					s 2 1 No 3 ☐ F	Probably 4 🗆 Unknown	
omplet	24a. Was an autopsy performed?					ed? prior to		
Be Co	25. Was case referred to medical			26. Place of Deal	1 ☐ Yes 2 th (Check only one	Maria 1 □ Ye	s 2 No	
10 E	examiner? 1 ☐ Yes 2 1 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ E	ome 5 Residence 6 Other (Specify)						
ation:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28b. Time of Injury	28c. Injur Work M 1 🗆	yat <br Yes 2 □No	28d. Describe how	v injury occurred		
ertifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stree	et, factory, office		28f. Location (Str. City or Town,	eet and Number or F State)	Rural Route Number,	
Medical Certification: To	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination and manner stated.	edge, death on and/or inve	occurred at the tile estigation, in my o	me, date and place ppinion, death occur	, and due to the ca rred at the time, da	use(s) and manner atte and place, and du	as stated. le to the cause(s)	
Me	29b. Signature and title of certifier		29c. Licens		_	d. Date signed (Mor		
	ALLOCAS	>	D42979			June 10, 2009		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Michael A. Carclucci MD 401 North Broadway, Balhmorem.) 21231							
ite ar	31. Date filed (Month, Day, Year) . Registrar's Signal .	re park	las					

DHMH 17 Rev 1/2001

State

Registrar

WILLIAM TANNER MD.

JUN 11

31. Date filed (Month, Day, Year)

11701 LIVINGSTON RD. FT. WASHINGTON, MD.

# Varvum, Albert

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Division of Vital F	
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			State of Maryland / Department of Healt  1 - State Registrar Certificate of Dea		-	giene Reg. No. 20(	9 18751	
	_		Decedent's Name (First, Middle, Last)	2. Date of Dea	th	3. Time of Death		
	Physicia /Medic		Albert H. Varnum, Jr.		Month June	9, 200	9 12:15 P <sup>M</sup>	
- Are	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Locati		4c. County of I			
المستعدية			Greater Baltimore Medical Center Towson  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Un	Baltimo	Birthplace (State or Foreign			
	Funeral Director		027-09-9520 1 M 2 F 98 Yrs. Months Days Hou	, Year) , 1911 M	Country)			
	put &		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits	
	Maryla f sho	ō	MD Baltimore Baltimore				1 ☐ Yes 2 <b>X</b> No	
	r 28a-	Director	10e. Street and Number 10f. Zip Code			10g. Citizen of Wha	t Country?	
	hould be filed within 72 hours after death with the Maryland to Mental Hygiene. marked other than "natural", or items 23a or 28a-f show imatic event, it a Medical Examination to notified.	ralD	2703 Glendale Road 21234			U.S.A.		
	er dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic If Yes, specify Cuban, Mex	ic Origin? (Spec xican, Puerto Ri	ify Yes or No- ican, etc.)	14. Race - Black, \	American Indian, Vhite, etc.	
36	irs afte	by F	1 □ Never Married 2 Married 1 □ Yes 2 No If Yes, Give 1 □ Yes 2 No Sper Year or Dates:	pecify:		Specify:	Specify: White	
5-0036	'2 hou natura lical E		15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during the following the f	most of working	,	16b. Kind of Busin	ess/Industry	
21	ithin 7 ne. han "r	Completed	Elementary/Secondary (0-12) College (1-4or 5+)  1.2 Machinist  Machinist	most of working	<b>'</b>	Bendix Ra	dio	
21	filed within Hygiene. other than "	CO	12	Mother's Name (	First. Middle.	Maiden Surname)		
Maryland	ould be the Mental arked o	To Be		Oma A. E				
ary		F	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and No.	lumber or Rural	Route Numbe	er, City or Town, Sta	ate, Zip Code)	
	and 2 lealth a m 27 is		Frances Varnum/ Wife 2703 Glendale					
altimore,	Pages 1 and 2 nent of Health a int: If item 27 is iry or other trai		20a. Method of Disposition  1 Z Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  Dulancy Valley	0 6/13/0		20c. Location - Cit		
	permit. Page Department of Important: If any Injury or once.		Memorial Gardens	1				
n	Dep Imp any		21. Signature of Funeral Service Licensee  22. Name and Address of F. Evans Fune i 8800 Harfor	rai Chap rd Rd. P	er & Cro arkville	emationSer e, MD 212	rvices 34	
'n			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, sucl shock, or heart failure. List only one cause on each line.	ch as cardiac or	respiratory ar	rest,	Approximate Interval Between	
- I	Physician		Immediate Caust Final dispuse or condition a. Hypoxic Rophzatory Fau resulting in death)			6 hows		
	/Medical Examiner		Due to (or as a consequence of):	b. Due to (or as a consequence of):  Due to (or as consequence of):			10 days	
		Jer	if any, leading to immediate  b. Due to (or as consequence of):				10001	
5	ecuted ind transit	Examin	Six tunificilly list our afterns if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  c.					
58760,	icate be executed physician and s the burial-transit		resulting in death) Last					
289	ificate g phys is the	edical	d					
X Q Q	leath certific attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the part 12 months?  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy			23d. Date of		
E	law requires that the death as been signed by the atter 2 should be detached for u	sicis	in the past 12 months?  1   Yes   2   No   4     Pregnant at time of death   5   Other (specify)     9   Unknown   9   Unknown				Month Day Year	
Ţ.	that the de ned by the a detached t		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in P	23e. Did tobacco use contribute to the cause of death?				
rds	w requires that s been signed k should be deta	d by		1 Yes 2 No 3 Probably 4 Unknown				
Hecords,	aw rec is bee 2 shou	Completed			24a. Was a	an 24b. We	re autopsy findings available or to completion of cause of	
Ĭ	The law ate has page 2 t	Som			autopsy performed? prior to completion of cause of death?  1 □ Yes 2 □ No 1 □ Yes 2 □ No			
VItal	Physician; r this certific ral director, p	Be	25. Was case referred to medical an examiner? 26. Place of Death (Check only one)					
0	Phys r this ral dir	<u>ات</u>	TEMPATIENT 2 EH/Outpatient 3 DOA 4	The state of the s				
0	Attending r death. ector; Afte by the fune	atior	27. Manner of Death  1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation  28a. Date of Injury (Month, Day, Year)  (Month, Day, Year)  28b. Time of Injury 28b. Time of Injury 4 Work?  1 ☐ Yes 2			,,		
DIVISION	r Atte ter dea rector	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28	3f. Location (S City or Tow		or Rural Route Number,	
5	urs aft	Se						
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical	29a. Certifier  (Check cnly one)  Check cnly one)  1	date and place, and	d due to the cause(s)			
	To th within To th compi	Me	29b. Signature and title of certifier 29c. License numb	nber		29d. Date signed (		
			Medical Doctor   D6331	12		JUNE	10,2009	
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Allison Habas ABMC 6701 N/MALL St		uson,	MD -	21204	
	Sta	te	The soul of the so	11 (00	USU(1)	1112		
	Registr		31. Date filed (Month, Day, Year)  22. Registrar's Signature  A. Aparlel					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month :14 AM wistand 4c. County of Death -1 da /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner win 8. Date of Birth (Month. Day. yrs. last birthday) **Funeral** 1 □ M 2 🗶 F Days 077-26-1587D 92 02/15/1917 Yrs **POLAND** Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 3414 ASSOCIATED WAY, #401 21117 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, and 2 should be filed within 72 hours after of leath and Mental Hygiene. m 27 is marked other than "natural", or iter Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: WHITE If Yes, Give Year or Dates 1 ☐Yes 2 No Specify: 2 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BUSINESSWOMAN F00D 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be KALMAN PORTER DEVORAH UNKNOWN ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 ls CARL VERSTANDIG / SON 13 KEYSER WOODS COURT, BALTIMORE, MD 21208 permit. Pages 1 a
Department of He
Important: If item
any injury or othe 20b. Place of Disposition (Name of MCSES) MONTE PYORGACE) WOODMOOR HEBREW CEM 06/10/2009 20c. Location - City or Town, State 20a. Method of Disposition 1 D Burial 2 □ Cremation 3 □ Removal from State BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ture of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Due to (or as a consequence of): /Medical Examiner Merchia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Exami the attending physician and hed for use as the bunal-tran Due to (or as a consequence of): P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, should I 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has certificate 1 ☐ Yes 2 ☑No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 XNo 1 Monpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director;
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Tospital Rangifitana

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

	Reg. No	U	U	2	_ !	0	- 1	U	
aii	1 Tygiene	$\cap$	$\cap$	0	1	Ω	7	5	

Physician
/Medical
<b>Examiner</b>

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Examirer must be rediffed at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	1 - For State Registrar	olalo ol marylan		tificate of Dea		, ,	eg. No 2009	18753
	1. Decedent's Name (First, Middle, Last)			-		2. Date of Deat	th	3. Time of Death
n	Elmer E. V	Walker				Month June	07 2009	09:35 PM
ıl r	4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or Loca	tion of Death		4c. County of Deat	n
	5621 Ballman Avenu	ae		Brook	lvn		Ann Ar	undel
_	Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year   If U	nder 24 Hrs.	8. Date of Birth	9 Birtl	nplace (State or Foreign
	220-22-5856	M 2 D F	81 Yrs.	Months Days Ho	urs Min.	(Month, Day, May 26	(Year) Co	MD
	Usual Residence of Decedent							12.1.1.1.02.11.2
_	10a. State 10b. County		y, Town or Loc		_		10d. Inside City Limits	
5	Maryland Anne Ar	undel		Brook	¢⊥yn			1 ☐ Yes 2 ☑ No
runeral Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	untry?
_ _ _	5621 Ballman Aven	ue		212	225		USA	
je l	11. Marital Status	12. Was Decedent Ever in U.	S. 13. W	as Decedent of Hispani Yes, specify Cuban, Me	c Origin? (Spe	cify Yes or No-	14. Race - Ame	
2	1 Never Married 2 Married	Armed Forces? 1				Rican, etc.)	Black, White	, etc.
<u></u>	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	□Yes 2√ No Spe	ecify:		Specify: W	hite
De l	15. Decedent's Educ	eation	16a. Deced	ent's Usual Occupation			16b. Kind of Business/l	ndustry
ble	(Specify only highest grade	Completed) College (1-4or 5+)	(Give k life. D	ind of work done during O NOT use retired)	most of working	ng		
	8	College (1-40/ 5+)		Superviso	r		Westin	ghouse
se Completed	17. Father's Name (First, Middle, Last)					(First, Middle, I	Maiden Surname)	911040
ומ	Elmer Walke	er		F	Ella	Marie	Gerho]	d
=8	19a. Informant's Name/Relationship (TV)		19h Mailine	Address (Street and N				
	Elizabeth A. Walke	· .	Ι .	. Ballman Ay				ip code)
- 55	20a. Method of Disposition						20c. Location - City or	Town State
	1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State		ition (Name of atory or other place)	June	TT	200: 200anon Ony or	own, own
	4 □ Donation 5 □ Other (Specify)			1 Cemetery	1		Baltimore,	
- 1	21. Signature of Funeral Service License	e, /	22.	Name and Address of F				
	Jud 1	\ [/]					dena, MD 21	.122
	23a. Part 1. Enter the disse, or complishock, or heart failur. List only on	at ins the caused the death	. Do not ente	r the mode of dying, suc	ch as cardiac o	r respiratory arr	est,	Approximate Interval Between
	Immediate Cause (Final disease or condition	BRAIN	TUN					Onset and Death
	resulting in death)	Due to (or as a consequ	<u> </u>	16 40				<del></del>
-1								
<u> </u>	Sequentially list conditions, if any, leading to immediate  Cause (Disease or injury	Due to (or as a consequ	ience of):					
Ħ	Cause (Disease or injury							
Examine	that initiated events c. resulting in death) Last	Due to (or as a consequ	ience of):					
2								
ealcal	a a							
5	IF FEMALE:	3c. If yes, outcome of pregna	ncv				Old Date of dol	lucari.
riiysicidiiyi	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d	death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of del Month	Day Year
	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown	eau 5	Other (specify)				
	Part II. Other significant conditions con	tributing to death but not resu	ilting in the un	derlying cause given in F	Part I	23e. Did tol	bacco use contribute to	the cause of death?
combiered by	0.10	_	ULMO		EASE	1 □ Ye	es 2.⊠No 3 □ Pr	obably 4 ☐ Unknown
2	11. 11. 11. 11.	Carrina	0	101110	2130	1010		and the second
5						24a. Was a autops	n 24b. Were au	topsy findings available completion of cause of
₹						perform	med? death? 2 ⊈No 1 □ Yes	<u> </u>
2	25. Was case referred to medical examiner?			26.	Place of Death	(Check only on	ne)	
2	1 Yes 2 100 H	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3 ☐ DOA Other: 41	☐ Nursing Hor	ne 5 Neside	ence 6 Other (Spe	cify)
1	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	2	8d. Describe ho	ow injury occurred	
	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(month, buy, rear)	injury	M 1 ☐Yes	2 □No			
<b>≧</b>	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho	me, farm, stre	et, factory, office	2	8f. Location (St	treet and Number or Ru	iral Route Number,
Jest IIII cationi.	- I Homicide	building, etc. (Specify	"/		1	City or Towi	i, State)	
6	29a. Certifier 1 Certifying Phys	sician: To the best of my know	wledge, death	occurred at the time, da	ate and place, a	and due to the o	cause(s) and manner as	s stated.
בחוכשו	(Check only 2 ☐ Medical Examir one)	ner: On the basis of examination and manner stated.	tion and/or inv	estigation, in my opinior	n, death occurre	ed at the time, d	late and place, and due	to the cause(s)
E -	29b. Signature and title of certifier			29c. License num	ber	2	29d. Date signed (Monti	h, Day, Year)
	* Killy	amazue, i	u.D.	17	753		6/8/0	9
-	30. Name and odderna of	malated serves of doubt //tem	00-) /T C	laine#\				
	30. Name and address of person who con	STENA Mel)	3 7 2	POTEE S	1. R.	ALTIMO	ORE. MD.	2/225
		32. Registrar's Signal	ure.	J			- /	
	31. Date filed (Month, Day, Year)	Denesta A.	Book	D				

State Registrar

		• • • • • • • • • • • • • • • • • • • •	Print in Black In			<del>-</del>	-	
		For State State Registrar	of Maryland / Dep <i>Ce</i>	ertificate of l		, ,	eg. No.?	18754
Physicia		Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
/Medic	al .	4a. Facility Name (If not institution, give street and r.		4h City Town or	Location of Death	June 1	10, 2009 4c. County of Dea	8:55 PM
Examine	er	9511 Ridgeview Driv			ımbia		How	
Funeral		5. Social Security Number 6. Sex 1 □ M 2℃¥	7. Age (In yrs. last birthday 61 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) C	rthplace (State or Foreign country)
Director		Usual Residence of Decedent				04/02/1	1948 Wasi	ningtan D.C.
// Aarylan f show ed at	or	10a. State 10b. County Howard	10c. City, Town or L	ocation Columbia	ì			10d. Inside City Limits 1 🖎 es 2 □ No
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	10e. Street and Number 9511 Ridgeview Dr	ive	10f. Zip Code	046	10	og. Citizen of What C	ountry?
death	inera		ecedent Ever in U.S. 13 Forces?	. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
ours after ral", or its Examine		1 □ Never Married 2 Narried 1 □ Yes, If Yes, Year or	s 2 <b>∄</b> No Give Dates:	1 ☐ Yes 2 🗗 No	Specify:		Specify:	White
in 72 h I "natu ledical	Completed	15. Decedent's Education (Specify only highest grade completed	d) (Giv	edent's Usual Occup re kind of work done o DO NOT use retired	ation during most of work d)	ing	16b. Kind of Busines	3/Industry
ed with /giene. er thar	E O	Elementary/Secondary (0-12) College	(1-4or 5+)	ffice Ma			Electro	nics
uld be file Mental Hy arked oth	To Be (	17. Father's Name (First, Middle, Last)  Leon Sherman			18. Mother's Name	an (	Cohn	
and 2 sho saith and n 27 is ma er trauma		19a. Informant's Name/Relationship (Type. Print)  Jeffery L. Weiner /		-			ia, MD 210	
Pages 1 arent of He int: If Item		20a. Method of Disposition  1 □ Burial 2 🛱 Cremation 3 □ Removal fro  4 □ Donation 5 □ Other (Specify)	m State 20b. Place of Dispose Commetery, characters C	position (Name of ematory or other place rematory	<sup>ce)</sup> 6/11	/2009	20c. Location - City of Hanover,	
permit. Departri Importa any inju		21. Signature of Funeral Service Licensee Doro		Name and Address Maryland PO Box 1	s of Facility 1 Cremat 413, Ba	ion Sei ltimore	rvices e, MD 21	203
10		23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause of	t caused the death. Do not en each line.	nter the mode of dyir	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	to (or as a consequence of):	toyla	si (	mcer		3 years
Examiner								J
ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	to (or as a consequence of):					
	Exar	resulting in death) Last C	to (or as a consequence of):					
icate be exphysician the buriant	dical	d						
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the but	by Physician/Medical	23b. Was decedent pregnant	egnant at time of death 5	□Ectopic pregnanc	у		23d. Date of d Month	lelivery Day Year
that the	/ Phy	Part II. Other significant conditions contributing to	death but not resulting in the	underlying cause giv	en in Part I.	23e. Did tol	bacco use contribute	to the cause of death?
equíres en sigr ould be	ed b					1 □ Ye	es 2 <mark>⊈N</mark> o 3□	Probably 4 Unknown
sician: The law re certificate has be irector, page 2 shc	Completed					24a. Was a autops perfori 1∐ Yes	n 24b. Were prior to death?	
ician: certific ector,	Be	25. Was case referred to medical examiner?  1		ont 3D DOA Oth	26. Place of Deat			
g Phys er this eral dir	7: To	27. Manner of Death 28a. Da	☐ Inpatient 2 ☐ ER/Outpatient 2 ☐ ER/Outpatient 28b. Time	of 28c. Inju	4 LI Nursing Ho		ence 6 Other (Sp ow injury occurred	pecify)
ending eath. or: Aftu	ation	2 Accident investigation	lonth, Day Year) Injury	M 1□	Yes 2□No			
tal or Att rs after de al Direct led in by t	Certification:	4 Homicide determined bu	ace of injury - At home, farm, s ilding, etc. <i>(Specify)</i>			City or Towi	n, State)	Rural Route Number,
To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) 1	the best of my knowledge, de e basis of examination and/or anner stated.	investigation, in my	opinion, death occur	rred at the time, o	fate and place, and d	lue to the cause(s)
Tot with Tot	Σ	29b. Signature and title of certifier	Cina. M	29c. Licens	1828	2	Sune (Mo	nth, Day, Year)
91		30. Name and address of person who completed co	1 Georgia A	ve #33	7 Silve	y SWin	19. MD 2	.0902
Sta Registr		31. Date filed (Month, Day, Year) 32	. Registrar's Signature				U	
HMH 17 Rev 1/20		JUNI I ZUUS Klein	is park					

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Ma	aryland	-	artment of H rtificate of		nd Mental H	,	2009	18755
			1. Decedent's Name (First, Middle	. ,			inoute or	Dodin	2. Date of E	Reg. No.		3. Time of Death
	Physici /Medio				ilso	n 			June		2009 <sup>ear</sup>	11:56 <sup>P M</sup>
	Examin	er	4a. Facility Name (If not institution 3912 Nicho.	lson Street	t		4b. City, Town, o	tsvil			County of Death	eorge's
	Funeral Director		5. Social Security Number 212–90–7420	6. Sex 7. Ag	e (In yrs la	a <i>st birthd</i> ay) Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of E Min. 10/09/	Sirth Day, Year) 1968	9. Birth Cou	place (State or Foreign ntry) MD
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
	e Mary Ba-f sh	ctor	MD Prince	George's			Hyat	tsville	е			1X Yes 2 □ No
	th with the 23a or 28 ast be no	Funeral Director	10e. Street and Number 3912 Nicholso	n Street			10f. Zip Code <b>207</b>	82		10g. Citiz	zen of What Cou USA	ntry?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is fleaffed Exercitive trausal be recilled at ODGe.	þ	11. Marital Status  1XXNever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give			Was Decedent of F If Yes, specify Cub 1 □Yes 2 📉o	Hispanic Originan, Mexican, I Specify:	n? (Specify Yes or N Puerto Rican, etc.)		I4. Race - Ameri Black, White, Specify:	
21215-0036	vithin 72 ho ene. than "natu	Completed	15. Deceder (Specify only highe Elementary/Secondary (0-12)	t's Education st grade completed)  College (1-4or 5	i+)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retire	during most o d)	of working		nd of Business/Ir	
d 2	filed v I Hygie other i	Be Co	17. Father's Name (First, Middle,	,			Disable		s Name (First, Midd		ver Work Surname)	<u>cea</u>
ylan	Suld be Menta arked atic ev	To B	Bascom Wilso	n				Caro	olyn Ann	Tur	ner	
, Mar	and 2 sho ealth and n 27 Is m	1 22	19a. Informant's Name/Relations Carolyn A. Daws		. /		-		or Rural Route Nun ad, Glen			
Baltimore, Maryland	Pages 1 nent of Ha ant: If iten ury or oth	1 19	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		ce	metery, crer	sition (Name of natory or other place rematory	<sup>се)</sup> 6,	Date <b>/9/2009</b>		nover, N	_
Balt	permit. Departi Importa any inj		21. Signature of Funeral Service	Licensee Porota	emation baltim			203				
			23a. Part 1. Enter the disease, or shock, or heart fallure. List	complications that caused only one cause on each lir	the death.	. Do not ent		-		-		Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a Due to (or as	Han	11/9	-		_			
T	Examiner		Sequentially list conditions	b.	a consequi	once on.						
	ited nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last	Due to (or as	a consequ	ence of):						
o,	icate be executed physician and s the burial-transit	Exai	that initiated events resulting in death) Last	c Due to (or as	a consequ	ence of):						
68760,	physical	edical		d								
O. Box 6	Physician: The law requires that the death certific this certificate has been signed by the attending praid director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1  Live birth 4  Pregnant a 9  Unknown	2 Fetal	death 3 [	Ectopic pregnand Other (specify)	çy			23d. Date of delive Month	very Day Year
s, P.	iires that signed b d be deta	by Pt	Part II. Other significant condition	ons contributing to death b	ut not resul	ting in the u	nderlying cause giv	en in Part I.	23e. Dio	d tobacco u		the cause of death?
ord	w require s been si should t	eted	De	pression					_	Yes 2	1	
Vital Records,	ician: The law certificate has t ector, page 2 s	Completed							24a. Wa au pe 1 □ Yes	topsy rformed?	24b. Were aut prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of 2 □No
Vit	ysiciar is certif directo	To Be	25. Was case referred to medical examiner?  12 Yes 2 ☐ No	Hospital:	ent 2 🗆 E		nt 3 □ DOA Oth	OF:	of Death (Check only sing Home 5 12 Re		S □Other (Spec	ifv)
	ding Ph	on: T	27. Manner of Death 1 ☐ Natural 5 ☐ Pendin	28a. Date of Inju (Month, Da	iry y, Year)	28b. Time of Injury	f 28c. Inju Wor	ry at ·k?	28d. Describ			ung
Division	Attender r death	Certification:	2 Accident investig 3 Solicide 6 Could 4 Homicide determ	not be	ury - At hor c. (Specify,	ne, farm, str	eet, factory, office	Yes 2	28f Location	(Street and	d Number or Rui	al Route Number,
Ω	spital o		29a, Certifier 1 ☐ Certifyir	ng Physician: To the best	of my know		h occurred at the ti	ime, date and	STREE	1/1/	( JEES V)	lle Mal.
	To the Hospital or within 24 hours afte to the Funeral Dir. completely filled in I	Medical	(Check only 2 Medical one)	Examiner: On the basis o and manner sta	f examinati	ion and/or in	vestigation, in my	opinion, death	n occurred at the tim	e, date and	place, and due	to the cause(s)
	To with	2	29b. Signature and title of certifie	en ble	A.	Do	29c. Licens	se number	27	29d. Date	e signed (Month	Day, Year)
	IV		30. Name and address of person	who completed cause of d	leath (Item	23a) (Type,	Print)	mire.	Chev	er(	4 Mx	ndan
	Sta Registr		31. Date filed (Month, Day, Year) JUN 1 1 2009	32. Registra	ar's Signat	are are						0

	Physici /Media Examir Funeral Director
Dailillore, Mai yiailu 21213-0030	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mydical Evant in any last be neithed any once.
	Physician /Medical Examiner
-	e executed ian and urial-transit

Division of Vital Records, P.O. Box 68760,

	For State Registrar		State of W	ai yiai iu	•	ficate of			Reg. No.	2009	1875		
ysician	1. Decedent's Name	e (First, Middle, La	ist)					2. Date of Month	Day	Year	3. Time of Death		
Medical		ra A. Waş											
aminer	,	, 0	re street and number, Medical			b. City, Town, c	or Location of D	eath 450T)	4c.	County of Death Balt	imore		
	5. Social Security N	umber 6.5		ge (In yrs. last		f Under 1 Year	If Under 24 I	Hrs.   8. Date o	f Birth	9. Birth	place (State or Fore		
eral ector	215-28-8		1 □ M 2√2 F	74	V- M	flonths Days	Hours N	Min.   (Month Sept	, Day, Year) 23, 19	34 Mar	yland		
	Usual Residence of										10.1.1		
N notified at Director	10a. State	10b. County		10c. City, T	own or Locati	ion					10d. Inside City Lin 1 ☐ Yes 2√☐		
scto	MD	Baltimor	e	]	Towson								
	10e. Street and Nur		1 0 .	# 0		10f. Zip Code	1204		10g. Citizen of What Country?  USA				
over crust b	8422 Cha	arles Val	ley Court										
in a	11. Marital Status	<del>V</del>	12. Was Decedent Armed Forces	?	13. Was	s Decedent of I es, specify Cub	Hispanic Origin' an, Mexican, Pi	? (Specify Yes o uerto Rican, etc.	r No-	<ol> <li>Race - Amer Black, White</li> </ol>			
<b>同一一</b>	1 ☐ Never Marri	ied 24 Married	1 □Yes 2人 If Yes, Give Year or Dates:		1 🗆	Yes 2X∏No	Specify:			Specify: Wh:	ite		
ed ed	o 🗆 widowed	15. Decedent's E			 16a. Deceden	t's Usual Occu	pation		16b. Ki	nd of Business/I	ndustry		
Completed		cify only highest gr	ade completed)		(Give kind life. DO	d of work done NOT use retire	during most of	working	4.		·		
E	Elementary/Seco	ndary (0-12)	College (1-4or $1$	5+)	lice	nsed pi	ractical	l nurse	he	althcar	e		
BeC	17. Father's Name	(First, Middle, Last	t)	•			1	Name (First, Mic					
TO E	Edward And	lerson Ha	rvey				Rella	Emily H	lopkins	3			
once.  To Be Completed by	19a. Informant's Na	ame/Relationship Wagner/s			19b. Mailing A 8422 C	Address (Street Charles	t and Number o Valley	r Rural Route N Court	umber, City o	r Town, State, Z Son,MD	ip Code) 21204		
	20a. Method of Dis	position		20b. Plac	e of Disposition	on (Name of ory or other pla	uga)	Date	20c. Lo	ocation - City or	Town, State		
		Cremation 3 5	Removal from State	7	elery, cremati	ory or ourer pra	i i						
	21. Signature of Fu		nsee		22. N	lame and Addre	ess of Facility			•	a		
, od	R	onald S	Wade Dir	ector	Stat	te Anat	omy Boa	rd 655 l	W. Bal	timore S	Street		
	23a. Part . Enter t	he disease, or con	lications that cause	ed the death.	Bali Do not enter t	the mode of dy	ing, such as car	rdiac or respirate	ory arrest,		Approximate Interval Between		
n											Onset and Death		
al	disease or condition resulting in death)	en 🕜	a. Due to (or a	s a consequer	rce of):	LURE				-	To VV have from 1 's		
er						TIVE	PULMON	ARY DI	SEASE		5 YEAR		
je 📕	Sequentially list co if any, leading to im cause. Enter Unde Cause (Disease or that initiated events resulting in death)	nditions, mediate	Due to (or as	s a consequer	nce of):								
Examiner	Cause (Disease or that initiated events	injury	C.										
	resulting in death)	Last	Due to (or as	s a consequer	nce of):								
Aedical Examir		•	d										
Med	IF FEMALE:												
Physician/N	23b. Was deceden in the past 12		23c. If yes, outcome 1 ☐ Live birth	2 🔲 Fetal de	eath 3□E	ctopic pregnan	су			23d. Date of del Month	ivery Day Year		
Sici	1 ☐ Yes 2 ☐ 9 ☐ Unknown	□No	4 ☐ Pregnant 9 ☐ Unknown		th 5□0	ther (specify) _			_	West	24,		
Completed by Physician/N			contributing to death	but not requitir	na ia tha unda	vrlvina obuga ai	von in Part I	230	Did tobacco i	ise contribute to	the cause of death		
ğ	ran ii. Other signi	ilcant conditions	contributing to death	DGI HOI FESUILII	ng in the dride	ariyirig cause gi	verili i aiti.				robably 4 🗆 Unkn		
Completed	-			-				_		1			
n de								_	Was an autopsy	prior to	utopsy findings avail completion of cause		
ပ်									performed? 'es 2 No	death? 1 ☐ Yes	2 No		
tion: To Be C	25. Was case refer examiner?	red to medical	119-1					Death (Check of	only one)				
ုင	1 ☐ Yes 2 🔀			tient 2 EF		3 LI DOA				6 ☐ Other (Spe	cify)		
Certification:	27. Manner of Deat	h 5 □Pending	28a. Date of In (Month, D		Bb. Time of Injury	28c. Inju	rk?		ribe how inju	ry occurred			
cati	2 Accident 3 Suicide	investigation 6 ☐ Could not b					⊒Yes 2 □No						
Ē	4 ☐ Homicide	determined	Zoe. Flace Ul II	njury - At home etc. <i>(Specify)</i>	e, farm, street	, factory, office		28f. Locat City o	ion <i>(Street ar</i> or Town, State	nd Number or Ri e)	ural Route Number,		
edical	29a. Certifier (Check only		hysician: To the bes miner: On the basis	of examination									
Med	one)	title of anation	and manner s		· L   - L	200 1/25-	eo number		204 0	ite signed (Mont	h Day Yearl		
Medical Certificati	29b. Signature and		nie Con	10 100	pitalist	29C. Licen	ise number				_		
	- de	de 2	al non	ce, /4/)		1500	心出力!(	1	J(	ine 2,	1207		
	30. Name and addi	ress of person who	completed cause of	death (Item 2	3a) (Type, Pri	nt)							
	31. Date liled (Mol		M. D 745 V	trar's Signatur	ER DR	alls W Longs A by	WSON,	MARYL	and s	1204			
State	31. Date #ilea Work	un, Day, -Year)	32. Hegis	ırars Signatül	e ( )	A A							
istrar		JUN 1 1 2	009	m B	gran	Kel							
1/2001			-	-	-								

DHMH 17 Rev 1/2001

	For	State of Ma	•	•			/lenta	l Hygien	е		
_	1 - State Registrar		<i>C</i>	ertifica	te of Dea	ath 		Reg. N	<u>•2009</u>	18	757
n al	1. Decedent's Name (First, Middle, Last Charles Edv	vard \	loung	Ш			Mon	MG C	TH ZOC	3. Time of 022	5 M
er	4a. Facility Name (If not institution, give		ر المارين الملك	4b. City	Town, or Loca	1.1		40	C. County of Dea	ith	
	5. Social Security Number 6. Se	ex / 7. Age	(In yrs. last birthda	ay) If Unde Months		nder 24 Hrs. ours Min.	8. Date	of Birth	9. Bi	rthplace (State country)	or Foreign
	41.1.18336	M 2□F	45 Yrs.	. IVIOTILIS	Days	iviii.	7	30 63		AR	
	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location						10d. Inside Ci	ty Limits
cto	mb		Balt	imac	e					1 Yes	2 🗌 No
Dire	10e. Street and Number	44 1		10f. Zi	p Code			10g. C	itizen of What C	ountry?	
Funeral Director		ck. Ave	nue	o d	21223	in Origina /Co	o o itu Vo o	ar No	USA	erican Indian	
	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No		If Yes, spe	edent of Hispan edify Cuban, Me	exican, Puerto ecity:	Rican, e	tc.)	14. Race - Am Black, Whi	te, etc.	
Completed by	3 ☐ Widowed 4 ☑ Divorced  15. Decedent's Edu	Year or Dates:	16a De		ual Occupation	oony.		16b	Specify: <b>B</b> . Kind of Business		
plet	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+	(Gi	ive kind of wo	ork done during	most of work	ring		)	, madding	
	124				hiet				ulin	ary	
Be	17. Father's Name (First, Middle, Last)	Varion	T-		18. /	Mother's Name	e (First, I	Middle, Maide	n Surname)	^	
2	19a. Informant's Name/Relationship (T)	ype. Print)	19b. Ma	ailing Addres	s (Street and N	lumber or Rur	ral Route	Number, City	or Town, State,	Zip Code)	
	Brenda MCB	ride M	10ther 20	HH F	reder	ick A	be.	Bal	to.m	Dala	23
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	20b. Place of Dis cemetery, c	sposition (Na crematory or o	me of	;	Date		Location - City o		
	4 ☐ Donation 5 ☐ Other (Specify)	)	Atlan:	fiz ('1	emator	46-10	0-0	9 (9	len Bu	rnie Y	nd
	21. Signature of Funeral Service Licens	Greene		5151	nd Address of I	more	Na	t. 40	eene Fur	eral Der	·
	23a. Part 1. Enter to disease, or composhock, or heart failure. List only o	fications that caused to one cause on each line	he death. Do not o	enter the mo	de of dying, suc	ch as cardiac	or respira	atory arrest,		Approximate Interval Bet Onset and I	ween
	Immediate Cause (Final disease or condition resulting in death)										
	f										
Jer I	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):	Section 1		,					
Examine	Cause (Disease or injury that initiated events resulting in death) Last	c. Pue to (or as a	mon (a) consequence of):	y 1	+ y por	tonsi	m				
dical E		d.		/	( "						
Medi	IF FEMALE:										
be completed by Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2	Fetal death	3 🗆 Ectopic				13	23d. Date of de Month		Year
ysic	1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at t 9 ☐ Unknown	ime of death	5 Other (s	pecify)					,	
2	Part II. Other significant conditions co	intributing to death but	not resulting in the	e underlying o	cause given in I	Part I.	23e	. Did tobacco	use contribute	to the cause of c	death?
ב ב								1 ☐ Yes	2 □ No 3 □ F	robably 4 🔯 l	Unknown
							24a	. Was an autopsy	24b. Were a	autopsy findings completion of c	available ause of
5							1 🗆	performed? Yes 2 10 N	death? lo 1 ☐ Ye	s 212 No	
	25. Was case referred to medical examiner?	Hospital:			Other:	Place of Deat			S/a	ASONS IT	Spire
-	27. Manner of Death	28a. Date of Injury	/ 28b. Time	e of	28c. Injury at	☐ Nursing Ho		Residence scribe how inj	6 <b>☑</b> Other (Sb ury occurred	ecify) - IIC	
	1 Natural 5 ☐ Pending investigation	(Month, Day,	Year) Injury	м	Work? 1 □ Yes	2 □ No					
	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury building, etc.	y - At home, farm, (Specify)	street, factor	y, office		28f. Loca City	ation (Street a or Town, Sta	and Number or F te)	Rural Route Num	nber,
Medical Certification: 10	29a. Certifier (Check only one)  (Check only one)  Certifying Phy 2 ☐ Medical Exami	/sician: To the best of iner: On the basis of and manner state	examination and/or	eath occurred r investigation	d at the time, da n, in my opinior	ate and place, n, death occur	, and due	to the cause e time, date a	(s) and manner nd place, and du	as stated. ue to the cause(s	s)
S -	29b. Signature and title of certifier	2			c. License num			29d. D	ate signed (Mor	nth, Day, Year)	
	> Neluaty/-	Huten			14459	3/		Jv	no 9th	1 2009	
	30. Name and address of person who co	ompleted cause of dea	ath (Item 23a) (Typ	pe, Print)	10 0		S	16 200	Baltin	MO	)
	Doberah =	I SINTO.	n 283	50 DW	1170 1	VGYIVO	201	10 403	· Willer	NO 110	
	11. Date filed (Month, Day, Year)  JUN 11 2009	32. Registrar			1174 1	VGYWO	J ( 1	10 205	· Millir	NG110	

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Sta Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Dav Year Arnold J. Yancheski 09 June 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 07/30/1938 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 212-36-8014 1 M 2 □ F 70 Maryland Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f shorthe Wedical Evention at must be notified at Maryland 1 es 2 No Director N/A Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 28 S. Madeira Street 21231 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 If Yes. Give Specify Specify: White þ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any injury or other traumatic event, the Marie once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 City Government Horticulturist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Yancheski Agnes Buza ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Yancheski / Wife 28 S. Madeira Street Baltimore, Maryland 21231 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 06/1272009 urial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Stanislaus Cemetery 21. Signature of Funeral Service 22. Name and Address of Facility David J. Weber Funeral Homes PA 401 S. Chester Street Baltimore, Maryland 21231 23a. Part 1. Enter the disease, of shock, or heart failure. List or omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** rentors disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to (or as a consequence of). cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed burial-tra Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) the 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ pe Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should certificate has been Physician: The law 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 1 ☐ Yes 1 ☐ Yes 2 🗆 No director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury After 28b. Time of 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending (Month, Day, Year) investigation after death Director: 2 Accident 1 ☐ Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide thin 24 hours a hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 7 29b. Signature and tittle of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AN VES 0

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

2009

3. Registrar's Signature

		1 - For State Registrar  1. Decedent's Name (First, Middle,	State of Maryla		artment of F rtificate of	Death	Reg.	No. 2009	1875 3. Time of Death	
Physici /Medic Examin	cal	Ariadni 4a. Facility Name (If not institution, Lorien Mt · Air 5. Social Security Number	4		4b. City, Town, o	,	5 Z	4c. County of Death		
Funeral Director		508-52-3313 Usual Residence of Decedent	6. Šex 1 □ M 2\$2 F 7. Age (In yr 7 9	rs. last birthday) Yrs.	Months Days	Hours Min.	Date of Birth (Month, Day, Ye 10/26/1	.929 Gr	place (State or Foreigntry) BECE	
8a-f show otified at	ector	MD 10a. State 10b. County MD Montgo		City, Town or Lo	Spring				10d. Inside City Limit 1 ☐ Yes 2 N	
23a or 2 ust be no	Funeral Director	10e. Street and Number 1135 Univers			10f. Zip Code 2090			Citizen of What Country?		
Ital Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	ρ	11. Marital Status  1 □ Never Married 2 □ Marrie 3 □ Widowed 4 ☒ Divorced	12. Was Decedent Ever in Armed Forces? d 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	ı	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 💆 No	lispanic Origin? (Speci an, Mexican, Puerto Ri Specify:	fy Yes or No- can, etc.)	14. Race - Ameri Black, White Specify: W		
ene. than "natu he Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 1 2	Education grade completed)  College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire SMETICI &	during most of working d)	166	Retail	ndustry	
	To Be Co	17. Father's Name (First, Middle, L John N. Arvani	•			18. Mother's Name ( Eleni R		den Surname)		
t of Health and Mei If item 27 is marke or other traumatic		19a. Informant's Name/Relationshi Angela White/	Daughter			and Number or Rural zedale La				
		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp.	Hemoval from State   A	ll Sou	osition (Name of matory or other plants Cem.	5/26/	2009   G	ermantov	vn,Md.	
Departmen Important: any injury		21. Signature of Funeral Service L	well Mos	490 92	41 Colu	RINALDI I	d.Silve		Md2091	
nysician Medical		shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	a. Due (or a cons	e wence of	xy t	rilure	Ven	tilator	Approximate Interval Between Onset and Death	
xaminer	ner	Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Dua to (or as a cons	equence of):	lure	Chi	onic	,	Mens	
hysician and the burial-transit	cal Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Keev/ Due to (or as a cons	equence of):	anoin		mons			
attending p for use as 1	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pred 1 Live birth 2 F. 4 Pregnant at time of 9 Unknown	etal death 3	□Ectopic pregnanc □ Other (specify) _	y		23d. Date of deli Month		
been signed by the should be detached	by	Part II. Other significant condition  Malta arug	is contributing to death but not r	esulting in the u	nderlying cause giv	ven in Part I.		co use contribute to	_	
ate has page 2	Be Completed	Huper Herica 25. Was fase referred to medical examiner?	Now, colos	lely!	leime.	26. Place of Death	1 -	prior to c	topsy findings availab completion of cause o	
h. After this funeral di	Certification: To E	27. Manner of Death  1 Natural 5 Pending investiga 3 Suicide 4 Homicide 6 Could not determin	t be Ope Place of injury At	28b. Time of Injury	f 28c. Inju Wo M 1	ryat rk?  Yes 2 □ No	3d. Describe how	at and Number or Ru		
within 24 hours after death  To the Funeral Director: completely filled in by the	Medical Co		Physician: To the best of my k xaminer: On the basis of exam and manner stated.							
within To the compl	Me	29b. Signature and title of certifier	Reilly	ML	29c. Licens	se number 5474	19 M	Date signed (Month	n, Day, Year) 3 200	
)		30 Name and address of person w	ho completed cause of death (II	tem 23a) (Type,	01/14	use Aur	0 D-1+	Theire e	ick Wed	

Registrar DHMH 17 Rev 1/2001

State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Day Month **Physician** 10:05 PM MAY Frances V. Ahalt P006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 9. Birthplace (State or Foreign Country)

MD Boonsboro tahrnev eedi If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 4/18/1911 Social Security Number 7. Age (In yrs. last birthday, 6. Sex **Funeral** Months 1 □ M 2 □X 212-38-7786 98 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hjury or other traumatic event, the Medical Ever iner must be notified at once. 1 ☐ Yes 2 ☐ XNo Director MD Frederick Middletown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21769 USA 7514 Picnic Woods Rd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 XNo If Yes, Give Year or Dates: XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 21 No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5 + Elementary/Secondary (0-12) public schools teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be M. Foster Ahalt Sarah Virginia Shank ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Marsha Bowers (Niece) 9 Kenneth Dr., Walkersville, MD 21793 20a. Method of Disposition

1 ☑ Burlal 2 ☐ Cremation 3 ☐ Ro
4 ☐ Dynation 5 ☐ Other (Specify) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 3 Removal from State Lutheran cemetery 5/27/2009Middletown, MD <sup>22</sup> Name and Address of Facility Donald B. Thompson Funeral Home POB 18, Middletown, MD 21769 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 200 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Hospital or Attending Physician: The I 24 hours after death. Funeral Director: After this certificate ha this certificate 1 ☐Yes 2 ☐No 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 DOther (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 05-26-2009 Name and address of person who completed cause of death (Item 23a) (Type, Print) 1126 OPAL HETESTOW, MA 21740

State Regist<u>r</u>ar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician LEWIS DeLEON ARTHUR /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WICOMICO Coasta Hospice Alisbur. LAKE If Under 1 Year | If Under/24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 **M** M 2 □ F 93 SOUTH CAROLINA Director 547 28 8835 EBRUARY 26 1916 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f shov ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MARYLAND SNOW NILL WORCESTER 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21863 USA DYRES 7121 LANG ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give 1935 - 1939 Year or Dates: 937 - 1955 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 Specify: WHITE 1 □Yes 2 No Specify Completed by 3 ☑ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Many Injury or other traumatic events. Elementary/Secondary (0-12) College (1-4or 5+) 11TH GRADE GRAD. MAINTENANCE REPRIR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LEWIS W. ARTHUR LULA MAE STUTTS ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GALE 7053 DYRES LANE ROAD SNOW HILL MARYLAND 21863 LANK Baltimore, ewis 20b. Place of Disposition (Name of cemetery, crematory or other place)
CHRISTIAN CHURLHYARD
CENETERY 20a. Method of Disposition Date 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State SNOW HILL MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) MAY 29 2009 22. Name and Address of Facility FOX FUNCRAL HOME Signature of Funeral Service Licensee POBOX 278 n. Deligo TEMPERANCEUILLE, VIRGINIA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Dertens Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of): Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed and burial-tran Due to (dr as a consequence of) signed by the attending physician of be detached for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗌 Ectopic pregnancy Month Day 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Waknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 20 No certificate 1 ☐Yes 2 ☐No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 24 hours after death. e Funeral Director: After this completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number 2 33 Name in address of person who completed cause if death (Item 23a) (Type, Print) ramue 31. Date filed (Month, Day, 32. Regis

DHMH 17 Rev 1/2001

State Registrar **Physici** /Medi Examir

Funeral

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	1 = State Certificate of Death Reg. No.												
	1. Decedent's Name (First, Middle, La	ast)						2. Date of De			Vons	3. Tin	ne of Death
an - 🖎	Mary	Elizah	oeth		Adki	ns		Month May	2	•	Year 2009	0	820A <sup>M</sup>
a! er	4a. Facility Name (If not institution, gi	ive street and number)		4b. City,	of Death		c. County o						
C1	Berlin Nursing &			В	erli	n				Worce	estei	_	
			ge (In yrs. last birthda	y) If Under	1 Year	If Under		8. Date of Bi	rth		9. Birthpl	ace (St	ate or Foreign
	214-28-8510	1□M 2X)F	78 Yrs.	Months	Days	Hours	Min.	(Month, D. 4-4-1	931	"	Mary		d
	Usual Residence of Decedent		70										
	10a. State 10b. County		10c. City, Town or	Location							10	d. Insid	de City Limits
ţo	MD Worcest	tar	Whale	yville								1 🗆	Yes 2X No
irec	10e. Street and Number	LCI	Wildie	10f. Zip					10g. C	Citizen of Wh	hat Count	ry?	
0	11526 Longridge I	ane			2	21872				USA			
Jer	11. Marital Status	12. Was Decedent	Ever in U.S. 13	3. Was Deced If Yes, spec			igin? (Spe	cify Yes or No	0-	14. Race			ın,
Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 □Yes 2 🔀						rican, etc.)			, White, e		
by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □Yes 2	ON LA	<i>Specify:</i>				Specify:	Wh:	Lte	
Be Completed by Funeral Director	15. Decedent's E	Education	16a. De	cedent's Usua	I Occup	ation	t of workin		16b.	Kind of Bus	iness/Ind	lustry	
ם	Elementary/Secondary (0-12)	College (1-4or	5+)	ve kind of wor DO NOT us	e retirea	) )	t or workin	iy					
Ñ	12		Home	maker						Own Ho			
Э <u>е</u>	17. Father's Name (First, Middle, Las	st)				18. Mothe	er's Name	(First, Middle	e, Maide	en Surname	)		
To I	Claude	S.	Donaw	ay, Sr	•	Eliza	abeth	t		Α.		W	lest
ľ	19a. Informant's Name/Relationship	(Type. Print)	19b. Ma	ailing Address	(Street	and Numbe	er or Rura	l Route Numb	ber, City	or Town, S	State, Zip	Code)	
	Donna M. Aydelott	te - Daught	ter   115	26 Lon	grid	lge La	ane,	Whaley	vil	1e, M	D 218	372	
	20a. Method of Disposition		20b. Place of Dis	sposition (Nam	ne of ther plac	e)	D	ate	20c.	Location - C	City or To	wn, Sta	te
	1 X Burial 2 ☐ Cremation 3 L 4 ☐ Donation 5 ☐ Other (Spec		Dale Cer			·	5-27	-2009	Wha	alevvi	i11e.	Ма	rvland
	21. Signature of Funeral Service Lice		1 2010 00	22. Name an		ss of Facilit		unds F					
	Molisso Als	20		705 E.	Mai	in St	reet,	Salis	bur	y, Mar	ry1aı	nd 2	21804
	23a. Part 1. Enter the disease, or cor	mplications that cause	d the death. Do not									Approx	
	shock, or heart failure. List only Immediate Cause (Final	y one cause on each li			-	Nh d	100-						and Death
	disease or condition resulting in death)	lesn	<u>-,                                      </u>				_						
		A Control	a consequence of):	U									
er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequence of):										
min	cause. Enter Underlying Cause (Disease or injury that initiated events												
/Medical Examiner	resulting in death) Last	CDue to (or as	a consequence of):										
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edic		u.											
Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								23d. Date	of delive	erv	
ciar	in the past 12 months?			3 □ Ectopic p 5 □ Other <i>(sp</i>		У				Mon		Day	Year
ıysi	9 Unknown	9 ☐ Unknown											
Be Completed by Physician	Part II. Other significant conditions	contributing to death b	out not resulting in the	e underlying ca	ause giv	en in Part I		23e. Did	tobacco	o use contri	ibute to th	ne caus	e of death?
d b								1 🗆	Yes	2 🗆 No	3☐ Prob	ably 1	Unknown
ete								24a. Was	s an	24h W	Vere auto	nsv finn	lings available
m D								auto	opsy formed?	pi	rior to cor eath?	mpletio	n of cause of
ပိ	25.44							1 ☐ Yes	<b>W</b>	No 1	□Yes	₽DN0	)
å	25. Was case referred to medical examiner?	Hospital:			Oth			(Check only					
<u>ٿ</u>	1 ☐ Yes V ☐ No 27. Manner of Death	1 ∐ Inpati	ient 2 ER/Outpa		DA   Diur	v at		me 5 Res				y)	
ion	Natural 5 ☐ Pending	(Month, Da	ay, Year) Injur	y M	8c. Injur Worl	yan k? Yes 2□	- 1	zou. Describe	TIOW III	july occurre	Ju		
icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not		iury - At home form			163 2		28f. Location	(Street	and Numbe	or or Rura	I Route	Number
ırtif	4 ☐ Homicide determine	d building, e	jury - At home, farm, tc. <i>(Specify)</i>	street, lactory	, onice		-	City or To	wn, Sta	ate)	or rrara	ii i ioate	, rannoon,
Medical Certification: To	29a. Certifier 4 Certifying F	Physician: To the best	of my knowledge de	eath occurred	at the ti	me date a	nd nlace	and due to th	e cause	e(s) and ma	nner as s	tated.	
lica		aminer: On the basis aminer si	of examination and/o										use(s)
Mec	29b. Signature and title of certified	and manner s	tarou.	290	. Licens	e number			29d. [	Date signed	(Month.	Day, Ye	ear)
	Los. Orginatore and title of Certifier	~		250		3155				5/24/		,,	
	1				Do.	) ' ' '			<u> </u>	2/2/	3/.		
	30. Name and address of person who	o completed cause of	death (Item 23a) (Typ	pe, Print)	C 4		.04 .	41	c. I.				
	31. Date filed (Month, Day, Year)	017 EAS	rar's Signatura	KE UT.	1 DA	11380	K-7 F	שר 2-18	SM.				
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Sta Registr 1 - For State Registrar

	T		1. Decedent's Name (First, Middle, Last)						2. Date of Month		ay Year	3. Time of Death
	Physicia /Medic		JESSIE	MAE	ABBO	TT			May	28		1:07 P M
	Examin		4a. Facility Name (If not institution, give street and	number)			4b. City, Town, or	Location of I	Death	4	c. County of Death	1
			117 Somers Cove Apartm	ents		1	Cr	isfiel	đ		Somerse	t
	Funeral		Social Security Number     6. Sex		(In yrs. last bi	irthday)	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of (Month,	Birth Day Yea	9. Birth	nplace (State or Foreign untry)
	Director		220-32-1643 1□ M 2⊠F	-	73	Yrs.	World bays	Tiours	May 17	, 1936		yland
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	show	_	10a. State 10b. County		10c. City, Tov							10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	ith the Marylan or 28a-f show	cto	Maryland Somerset			C	risfield					
	다 다 6 2 2	Dire	10e. Street and Number				10f. Zip Code			10g. (	Citizen of What Cou	
	72 hours after death wi "natural", or items 23a ideal Examinationst b	<b>Funeral Director</b>	117 Somers Cove Apartm	ents				21817			U.S.A	
	r de	nne		Forces?		13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origir an, Mexican, F	n? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Amer Black, White	
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3	hour tural		·	r Dates:	16:	Dogge	lent's Usual Occup	ation		16h	Kind of Business/I	ndustry
2	"na"	Set	15. Decedent's Education (Specify only highest grade complete			(Give I	kind of work done of NOT use retired	durina most o	of working	100.	Tellia of Dasifiess/	industry
7	s I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "rection Exa direction of	Completed	Elementary/Secondary (0-12) College 7	e (1-4or 5-		ssem	_	7		Fo	ood Proce	ssina
N .	filed Hygi ther	ပ္	17. Father's Name (First, Middle, Last)					18. Mother's	s Name (First, Mid			
8	of be sental red of cerve	Be C	Albert James Rich					Rhe	a Jeanet	te St	erling	
5	2 should be filed withi and Mental Hygiene. is marked other thar aumatic event, the	은	19a. Informant's Name/Relationship (Type. Print)		19	h Mailin	n Address (Street	and Number	or Bural Boute Nu	mber. Citi	y or Town, State, Z	in Code)
<u>2</u>	d 2 s Ith ar IT is trau		Harold F. Abbott (Husb	(bac			omers Co					1817
נֿע	1 an Hea Hem 2	- 4	20a. Method of Disposition	and)	20b. Place	of Dispos	sition (Name of	i	Date Date		Location - City or T	
2	ages int of t: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal fro	m State	1	-	natory or other plac	- 1	/20 /00			MD
	it. P		4 □ Donation 5 □ Other (Specify)  21. Signature a Funeral Service Licepse		Rich		ly Cemet		·		risfield,	MD
ם	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		Col 4/1/1/11	1			. Name and Addre					
		-	Robert H. Bradshaw, 23a. Part 1. Enter the disease, or complications the		the death Do		06 W. Ma				1D 21817	Approximate
	as		shock, or heart failure. List only one cause of	p-each lin	е.	1		19, 30011 03 00	ardiac or respirator	y uncon,	ļ	Interval Between Onset and Death
F	Physician /Madical		Immediate Cause (Final disease or condition resulting in death)	010			ier					
d.	/Medical Examiner		Due	to (or as a	a consequence	of):						
		Į.	Sequentially list conditions,	to (or as a	a consequence	ot).						
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	10 (01 40 6	Conocquence	01).						
_	execu and al-trai	xar	that initiated events c	to (or as a	a consequence	of):						
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2	eath certificate be executed attending physician and for use as the burial-transit	cian/Medical	d					**************************************				
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ว์ 🧻	leath atte	ciai	in the past 12 months?		2  Fetal deat time of death		Ectopic pregnanc Other (s <i>pecify)</i> _	У			Month	Day Year
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٠.	or Attending Physician: The law requires that the diafter death. Director: After this certificate has been signed by the in by the funeral director, page 2 should be detached		Part II. Other significant conditions contributing to	o death bu	t not resulting	in the ur	nderlying cause giv	en in Part I.	23e. D	id tobacc	o use contribute to	the cause of death?
3	uires n sign ld be	d by							1	□Yes	2 No 3 ₽ Pr	obably 4 🗌 Unknown
3	w rec	Completed							24a, W	/as an	24b. Were au	topsy findings available
ב ב	: The law cate has page 2:	щ							— а	utopsy erformed	prior to death?	completion of cause of
5 '	siclan: The certificate I rector, page		25. Was case referred to medical					00 Di	1 🗆 Ye		No 1 ∐Yes	2  \( \text{No} \)
> :	Physiclan: this certific al director, p	Be c	examiner?		nt 2 🗆 ER/C	utnation	t all DOA Oth		of Death (Check or		6 ☐ Other (Spec	- 14.4
5 i	Phy er this eral d	.To	27. Manner of Death 28a. De	ate of Injur	y 28b.	Time of	28c. Injur	y at			jury occurred	ony)
5	iding Ph th. : After th funeral	tjo	1 Natural 5 ☐ Pending (A 2 ☐ Accident investigation	1onth, Day	, Year)	Injury	M 1 🗆	ki? Yes 2.∐No	0			
2	Atter r dea ector by the	fica	3 Suicide 6 Could not be 28e, Pla	ace of Inju	ry - At home, f	arm, stre	eet, factory, office		28f. Locatio	n (Street	and Number or Ru	ıral Route Number,
5.	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	4 ☐ Homicide determined bu	uilding, etc	(Specify)				City or	Town, St	ate)	
	spita ours ours reral		29a. Certifier 1 Certifying Physician: To	the best o	of my knowledg	ge, death	occurred at the ti	me, date and	place, and due to	the cause	e(s) and manner as	s stated.
:	the Hospital hin 24 hours a the Funeral mpletely filled	Medical	(Check only one) 2 Medical Examiner: On the	ie basis of nanner sta		ınd/or in	vestigation, in my o	pinion, death	occurred at the ti	me, date a	and place, and due	to the cause(s)
	Within To the comp	Me	29b. Signature and the of certifier				29c, Licens	e number		29d.	Date signed (Monti	h, Day, Year)
	1		1 Commission	0	RA	A 51	Chi	541	+22		5-26	-2008
	Y		30/Name and address of person who completed c	ause of de	eath (Item? 23a)	(Type.	Print)		1 ^			-
	4		1604- Market - S	ナー)	loc	2	ste	pu	1) 2/18	35/		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** ELLEN MARIE BOSWELL JUNE 2009 7:02P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 2012 A WEDGEWOOD PLACE WALDORF CHARLES 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2√2 F Months Days Hours Min. MD. 56 218-54-9495 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a, State 10b. County 28a-f shov permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If lieu a 72 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Exert. 1 □Yes 2 No WALDORF CHARLES MD. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number WEDGEWOOD PLACE 20602 U.S.A. 2013A Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2X No Specify. ð 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) NAIL TECHNICIAN SELF EMPLOYED 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ANDREW CHRISTOPHER BUCKLER FLORENCE EDNA ROBEY ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RENEE BLANKENSHIP-DAUGHTER P.O.BOX 155 BEL ALTON, MD. 20611 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 20a. Method of Disposition ST. PETER S CEMETERY 6-9-09 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State WALDORF, MD. 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility
AYMOND FUNERAL SERVICE, P.A.
A PLATA, MARYLAND 20646 21. Signature of Funeral Service Licensee M00479 23a. Part 1. Enter the disease, or complications that laused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) a ISCHEMIC HEART DISEASE /Medical Due to (or as a consequence of): Examiner DIABETES MELLITUS, TYPE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed physician and s the burial-transit HYPERTENSION Due to (or as a consequence of). P.O. Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ DEGENERATIVE BONE DISEASE 1 ☐ Yes 2☐No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an was an autopsy performed? certificate Division of Vital 1 □ Yes Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1—∏Yes 2□No Certification: To 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☑ Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b, Signature and title of certifier D00550883 JUNE 5, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YAHIA Μ. TAGOURI 11655 WINESAP PLACE LA PLATA, MD 20646 M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signatur JUN 1 1 2009

DHMH 17 Rev 1/2001

Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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			Registrar     Decedent's Name (First, Middle)	e, Last	")								2. Date of I				3. Time of Death
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/Med Exam			4a. Facility Name (If not institution			umber)			4b. City, 7	own, or l	Location of	f Death		Ť	4c. Count	of Death	
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should and Me mark mark	F	2 .	19a. Informant's Name/Relations					19b. Mailir	ng Address	(Street a	and Numbe	er or Rura	il Route Nui	mber,	City or Towl	n, State, Z	Zip Code)
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JIVISION OI I or Attending Phy after death. Director: After this d in by the funeral d	1	Certification:		mined	28e. Plac bui	ce of Injur Iding, etc.	y - At hor (Specify	me, farm, sti	reet, factory	, office			City or	Town	, State)	nper or n	ural Route Number,
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To the Hospital or Attending Physician: The law requires that the death certification to the Hospital or Attending Physician: The law requires that the death certificate hours after death.  To the Funeral Director: After this certificate has been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as	:	Medical	(Check only 2 ☐ Medica one)	l Exam	niner: On the	basis of canner state	examinat	tion and/or in	nvestigation	, in my o	opinion, dea	ath occur	red at the ti	me, da	ate and plac	e, and du	e to the cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Jessica Alma Benedict 1- For State Certificate of Death Rea. No Registrar 2. Date of Death . Decedent's Name (First, Middle,Last) Physician/ June 4, 2009 0854 hrs Medical Examiner Jessica Alma Benedict 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Washington Washington County Hospital Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. . Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign **Funeral** Country) Months Hours Min 220-35-7543 Days 10/14/1987 Director 21 DC M 2 X F Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 X No MDWashington Hagerstown death with the Maryland Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 18114 Sky View Lane 21740 US Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. White, etc. Armed Forces? 1 X Never Married 2 Married Yes White Yes, Give Year Yes 2 X No specify: Specify. Pages 1 and 2 should be filed within 72 hours after 3 Widowed 4 Divorced marked other than "natural", c event, the Medical Examiner þ 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12 Sales Associate Communication 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) t of Health and Mental H
I frem 27 is marked
other traumatic event, t Carl Robert Benedict Unknown æ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carl R. Benedict / Father 18114 Sky View Lane, Hagerstown, MD 21740 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) it: If i Burial 2 X Cremation 3 Removal from State Department o Important: injury or oth 06/07/2009 Smithsburg, MD Smithsburg Crematory Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death Immediate Cause (Final disease Heroin intoxication raminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Physician/Medical 23a,27,28a-f,perME, g892 6/19/09 TT attending physician or use as the burial -X UNPENDED O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 🗸 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 ✔ No 3 Probably 4 Records, P. Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy has 2 st death? No certificate ✓ Yes 2 No 1 🗸 Yes Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: 1 Other<sub>4</sub> Nursing Home 5 Residence 6 Inpatient 2 ✓ ER/Outpatient 3 this 1 V Yes No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After 27. Manner of Death Certification: Natural Yes 2 X No Pending hours after death. Funeral Director: tely filled in by the Fd 6/4/09 Fd 8:30 am 2 Accident Investigation Location (Street and Number of Rural Route Number, City or Town, State) 757 Gifford Ave. 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be 3 Suicide or Town, State) /5/ GII t 2 Hagerstown, apartment determined (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 241 ca To the 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Med and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) June 5, 2009 O.C.M.E. Diasille 30. Namuland address of person who completed cause of death (Item 23a) OCME Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month Day Year) State

DHMH 17 Rev 1/2001 **OCME 2006** 

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 23,2009 Month **Physician** 7:45 A M May Virginia Brittingham Clara /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Regency Park Assisted Living Anne Arundel Gambrills | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month Day) | Hours | Min. | Jan 2, 1916 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 😾 F Maryland 220-05-7352 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 XYes 2 □ No Director Gambrills MD Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21054 730 Maryland Rt. 3 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No 11. Marital Status Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐Yes 2 XNo Specify. Specify: Completed by 3 XWidowed 4 ☐ Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) cafeteria 12 manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Henderson Robert Harris ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 504 Timber Woods Ct., Gambrills, MD 21054 Peggy Johnson (daughter) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/29/2009 Pocomoke City, MD First Baptist Cemetery 22. Name and Address of Facility. Holloway Funeral Home, Professional Association e of Funeral Service Licensee 107 Vine St., Pocomoke City, MD 21851 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Demenha Immediate Cause (Final 270 **に ア**ら disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if an, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death
9 ☐ Unknown 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months?
1 Yes 2 No 5 ☐ Other (specify) 1 ☐ Yes 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Nuknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐Yes 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) ☐ [ V \ NG 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27, Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide

/Medical Examiner or Attending Physician: The law requires that the death certificate be executed and Box 68760 attending physician Division of Vital Records, P.O. certificate After this To the Hospital Committee the within 24 hours after death.

To the Funeral Director: Af Hospital

**Funeral** 

Director

iral", or items 23a or 28a-f show Exemple: must be notified at

"natural", or

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene." Important: If item 27 is marked other than any Injury or other traumatic event, the MagnoRe.

**Physician** 

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

Examiner Physician/Medical ð Completed Be Certification: To 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifie

MAY 28 2009

063726

29d. Date signed (Month, Day, Year) May 123, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WAコミにのカルアル

BURNE NEBN 80122108

Kurmi

MAKYLAND

BA5 1406 CXLAIN 31. Date filed (Month, Day, Year) State

32. Registrar's Signature

HUANAY

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) May 25, **Physician** 2009 12:15 P M Booker Will /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Temple Hills 4403 Cedell Place If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sev 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year Min Months Days Hours 1**x**xM 2□ F 228-34-4540 80 Dec. 19. . V<u>irginia</u> Director 1928 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be rediffed at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Maryland Prince George's 1 ☐ Yes 2 XXXVo Director Temple Hills 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4403 Cedell Place 20748 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 █No If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Black. þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Transportation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ed Booker Pear1 Mosley ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Donna B. Rivers / Niece 4403 Cedell Place Temple Hills, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Wash. Nat'1. Cemetery 06/04/2009 Suitland, Maryland 4 Donation 5 Dother (Specify) George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on sach line. Approximate Interval Between Onset and Death Immediate Cause (Final theosileoti disease in vascule **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examine burial-transi Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy certificate 1 ☐Yes 2 No 25. Was case referred to medical examiner?
1 △ Yes 2 □ No Be 26. Place of Death (Check onl one) Hospital: Other: 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 1 🔲 Inpatient 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1XX Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, 24 hours after death.

Funeral Director: After this certificetely filled in by the funeral director, I

Baltimore, Maryland 21215-0036

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical within 2 and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 22010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Atwork R mas Ave 2000 900 was unpton 31, Date filed (Month, MAY 2 8 2 State MAY 28 Registrar

determined

4 Homicide

29a. Certifier

09-04428 Stacey Lynn Blake

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 1876
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		- For State Registrar	Certific	ate of Death		Reg. N	0.	, , , , , , , , , , , , , , , , , , , ,
Physicia	an/	Decedent's Name (First, Middle,Last)	1 1	t 11.		2. Date of Death  Month  Day	y Year	3. Time of Death 1240 hrs
→ Exami		Stacey	Lynn B	lake	Leastien of Dooth	June 3, 2009	4c. County of Dea	
		4a. Facility Name (if not institution, give str Easton Memorial Hospital	eet a/nd number)	4b. City, Town, or Easton	Location of Death		Talbot	
		5. Social Security Number 6. Sex	7. Age (In yrs. last bi		r If Under 24Hrs.	8. Date of Birth (M	M/DD/YYYY) 9. B	irthplace (State or
Funeral Director			2VF 43	Yrs. Months Days	s Hours Min.	Nov. 23	19/ <sub>2</sub> 5 Fore	country) Maryland
	- 1	218-86-6228 1 M Usual Residence of Decedent	2 <u>V</u> F / )	113.		1404143	1100	
a ny	ŀ	10a. State 10b. County	10c. City, Tow	n or Location				10d. Inside City Limits
<u> </u>	اءِ	MD Talbot	E	istow				1 Yes 2 No
Maryland 28a-f show	Director	10e. Street and Number		10f. Zip Code		10g. (	Citizen of What Co	
death with the Maryland or items 23a or 28a-f sho		406 Moton	Street Apt.	303 21	601		U5H	
ath with the items 23a ast be noti	era	11. Marital Status	2. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp	ecify Yes or No- Rican, etc.)	14. Race - Am White, etc.	erican Indian, Black,
death or ite	Funeral	1 Never Married 2 Married 1	Yes 2 No	1 Yes 2 V No			Specify: B	Lack
s after	à	3 Widowed 4 Divorced If your 15. Decedent's Education (Specify only I	Dates:	. Decedent's Usual Occupa		vork done 16	b. Kind of Busines	s/Industry
hour "natu	ted	Elementary/Secondary (0-12)	College (1-4 or 5+)	during most of working life	e. DO NOT use retir	red)		
36 hin 72 e. than	륄	10	,	Never	Work	ed	Nov	ne
5-0036 lled within 7 Hygiene. I other than	Completed	17. Father's Name (First, Middle, Last)		7 40 70 1	18.Mother's Name	(First, Middle, Maid	len Surname)	
215 be fill ontal H rked	Be	Alonzo	Jacobs		Barb	ara A	nn 131	ake
Me Me Si	To	19a. Informant's Name/Relationship (Type		9b. Mailing Address (Street		/	r, City or Town, Sta	ate, Zip Code)
MD and 2 sho m 27 is aumat		Barbara Ann	Blake 1	320 Hopk : of Disposition (Name of ce	NS Place	Date 2	Oc. Location - City	or Town, State
or He I ite		20a. Method of Disposition  1 X Burial 2 Cremation 3	Removal from State crem	atory or other place)		12120	1-01	110
Baltimore, permit. Pages I are Department of Hee Important: If ite Injury or other tr		4 Donation 5 Other Specify:		ard 5 Mem. Y	- C E 110 -			ow, MD.
Baltimo permit. Pag Department Important: injury or or	ļ, l	21. Signature of Funeral Service Licenser	Nous	Henry F	uneral	Home, P.	A. doe	110,21613
Physician		21. Signature of Funeral Service Licenses  C,  23a, P int I. Enter the disease, or complice	itions that caused the reath. Do	not enter the mode of dying	, such a cardiac o	or respiratory arrest,	shock, or nert	Approximate Interval Between Onset and
Medical	ļ.,	failure. List only one cause on each	<sub>line.</sub> noke and soot i					Death
_xaminer			e to (or as a consequence of):					
		Sequentially list conditions, b						
	Examiner	cause. Enter Underlying Cause	e to (or as a consequence of):					
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3760, ficate be g physic s the bur	Ž	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregnan  1 Live birth	cy 2 Fetal death 3	Ectopic pregn	ancy	23d. Date of deli Month	Day Year
30x 68 death certiff ne attending	cial	past 12 months?	4 Pregnant at time of death					
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ires that the signed by the detached	by P	Part II. Other significant conditions	ontributing to death but not resul	ting in the underlying cause	given in Part I.			Probably 4 Vulknown
- ii			<u> </u>		<del></del>	24a. Was an		e autopsy findings available
cords, law requin	를					autopsy	prior	to completion of cause of
Records, The law requin ficate has been s	Completed					1 Yes 2		Yes 2 No
Vital Reo ysician: The his certificate director, page	Bec	25. Was case referred to medical examiner?	onital:		Other Nursi			Mhor
of Vital ng Physician: After this certi	2	1:✔ Yes 2 No	spital: 1 Inpatient 2 V EF		jury at Work?	ing Home 5 Re 28d. Describe ho		Other:
n of ding Pl After funera		27. Manner of Death  1 Natural 5 Pending	(Month, Day, Year)	1	Yes 2X No	unk	,,	
Siol Atten death retor:	cati	2 Accident Investigation	290 Place of Injury - At home	d 12:3/ pm		28f. Location (Str	eet and Number o	or Rural Route Number, City
Division tall or Attending after death.	Certification:	3 Suicide 6 X Could not be determined	(Specify) house			or Town, Sta	<sub>te</sub> 406 Mot Easton,	MD
Division of Vital  Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifuled in by the funeral director.	ပိ	4 Homicide  29a. Certifier 1 Certifying Physician	To the best of my knowledge	death occurred at the time,	date and place, an	nd due to the cause	s) and manner as	stated.
ple the	Medical	one) 2 Medical Examiner:	on the basis of examination and/ and manner stated.	or investigation, in my opini	on, death occurred	at the time, date ar	nd place, and due	to the cause(s)
To with	Me	29b. Signature and title of certifier	na manner states.	29c. Lice	nse number			(Month, Day, Year)
		and 2		0.0	C.M.E.		June 4, 2009	
		30. Name and address of person who co		Ba)				
				1 Penn Street, Baltir	nore, MD 2120	J1		
	State		32. R. gistrar's Signature	1. Sand				
Regis	આહ	77.000	The state of the s					

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of	Marylan		rtment <i>tificate</i>			and Me	ental Hy	giene Reg. No.	ини	18770
	Physicia	an	1. Decedent's Name (First, Midda Mary Elizabeth								2. Date of De Month Iay		2009 <sup>Year</sup>	3. Time of Death 12:52 P M
	/Medic Examin		4a. Facility Name (If not institutio		per)		4b. City, To	wn, or L	ocation o			4c.	County of Dea	ath
4			Mallard Bay Ce		Ame (In tree	lant hirthdayl	Camb			24 Hrs.	R Date of Bi		orches	ter
	Funeral Director		5. Social Security Number 219-36-7216	6. Sex 7. 1 ☐ M 2 🛣 F	Age (In yrs. 79	Yrs.		Days	Hours	Min.	B. Date of Bi (Month, D June 2	ay, Year) 1,192	29 Was	hington, DC
			Usual Residence of Decedent		100 Cit	ty. Town or Lo	cation							10d. Inside City Limits
	f show	or	10a. State 10b. County Maryland Dorch			etary	cation							1 X Yes 2 No
7	r 28a-f	irect	10e. Street and Number	ester	beer	- Cully	10f. Zip C	ode				10g. Citi	zen of What C	ountry?
3	death with the Maryland ms 23a or 28a-f show	ralD	122 Second Stre	eet				.664						SA
) 9E0	or ite	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Mar 3 ☑ Widowed 4 ☐ Divorced		es? [ <b>X</b> No		Was Deceder fYes, specify 1 □Yes 2	_			ify Yes or Nican, etc.)	0-	14. Race - Am Black, Whi Specify: W	te, etc.
2-0	72 hor	eted	15. Deceder	nt's Education est grade completed)		16a. Dece	dent's Usual kind of work DO NOT use	Occupat done du	tion uring most	t of working	9	16b. Ki	nd of Business	s/Industry
121	within ene.	Completed by	Elementary/Secondary (0-12)	College (1-4	or 5+)		oo <i>notuse</i> eria M					  Elen	nentary	School School
d 2	il Hygi other	Be Cc	17. Father's Name (First, Middle,	Last)		I.				er's Name	(First, Middle	e, Maiden	Surname)	
ylar	wuld be Menta arked atic ev	To B	Robert Roche								Clint			
, Maryland 21215-0036	and 2 sho alth and 27 is m		19a. Informant's Name/Relations Spencer Bradle										or Town, State, 21631	Zip Code)
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", any injury or other traumatic event, I'm Medical Exp. once.		20a. Method of Disposition  1   Burial 2 □ Cremation  4 □ Donation 5 □ Other (5		are i	Place of Dispo cemetery, crei t New				Da 5/29/	ate 2009		New Ma	rTown, State arket, MD
Balti	permit. Departn Importa any Inju		21. Signature of Funeral Service		lew		Name and eller ast Nev					. Вох	207	
	Physician /Medical	(	23a. Part I. Enter the disease, of the control of t	t only one pause on each	nary	th. Do not en	er the mode	of dying	, such as			arrest,		Approximate Interval Between Onset and Death
T	Examiner				s a co	uence of):								5 Nave
	₽ #	iner	Sequentially list conditions, if any cause in g to mmodut cause. Enter Underlying Cause (Disease or injury	D	as a conseq	uence of):								3
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8760,	icate be executed physician and s the burial-transit	dical E		d										
O. Box 6	eath certif attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		rth 2□Feta int at time of o	al death 3	☐ Ectopic pre☐ Other <i>(sp</i> e						23d. Date of d Month	lelivery Day Year
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Vita	Physician: The this certificate al director, pag	Be (	25. Was case referred to medica examiner?	Hospital:				Other	- 4		(Check only			
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Divis	al or Atte s after de l Directo d in by th	Certification: To	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be nined 28e. Place o building	f Injury - At h g, etc. <i>(Sp</i> ec <i>i</i>	ome, farm, st	reet, factory,	office		2	8f. Location City or To	(Street ar own, State	nd Number or e)	Rural Route Number,
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical C	29a. Certifier 1 Certify (Check only one) 2 Medica	ing Physician: To the base and manner	sis of examina	owledge, dea ation and/or i	th occurred a nvestigation,	t the tim	ne, date a pinion, de	nd place, a	and due to the	ne cause(s e, date an	s) and manner d place, and d	as stated. ue to the cause(s)
	To the withing to the comp	Me	29b. Signature and title of certific	er			29c.	License	number				1 2	nth, Day, Year)
	2		> gypanis	on Nu			He	005	5 99	73			27/09	7
_	ر		30. Name and address of person Patricia	6 hnson	160	Bran		(	ame	brid	ge 1	no		
	Sta Registi		31. Date filed (Month, Day, Year	8 2009 32. Re	o strar's Sign	ature	book	1						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State of Marylar PHY. State of Marylar Registrar 5/27/09 AACO HEALTH DEPT. CMH Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 12:01p <sup>M</sup> MAY 20 Clarence L. Brookhart 09 /Medical 4b. City, Town, or Location of DeathGlen Burnie 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BWHC If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. Sep. 25, 1924 Anne Arundel 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 € M 2 □ F 212-20-4411 84 Maryland Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene.

m 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location items 23a or 28a-f shoviner must be notified at 1 ☐ Yes 2 No Anne Arundel Director MD Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 311 Fernwood Drive 21146 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 [XYes 2 □ No If Yes, Give Year or Dates: WW I 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 T Married 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White 2 3 Widowed 4 Divorced WW II Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Purchasing Manager Staley Machinery 4 17. Father's Name (First, Middle, Last) Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) Be William Brookhart Emma Hoehn ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois Jane Brookhart/Wife 311 Fernwood Drive Severna Park, MD 21146 permit. Pages 1 and Department of Healt Important: If item 27 any injury or other to 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition May 22, 2009 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Metro Crematory 21. Signalimo of Fun I al Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. 495 Gov. Ritchie Hwy. Severna Park Funeral Home Severna Park, MD 21146 Somo Approximate Interval Between Onset and Death 23a. Par11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) LUNG CANCER **Physician** DNE TRI /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Exami Due to (or as a consequence of) attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) signed by the a 9 Unknown 9 🗍 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð PEKIPHERAL AND CEREBRAL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed ANTERIO SCLEROSIS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate ha 1 ☐ Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending after death.

Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation is my opinion, death account of the cause (s) and manner as stated. 29a, Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AC1944885 20109 6, m , H.D , 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. CERINO H.D. 3001 S. HANOVER ST. GRUEHN BLDG. STE 207, BALTO! of ICH

Registrar
DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

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JASHI J

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5/22/2009 **Physician** James Anthony Bordes 505pm м /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Hospice Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1**√** M 2□ F Days Hours Min. 46 439-19-5491 6/8/1962 Director LA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantinal mast be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Annapolis 1 ☐ Yes X No Director Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21409 USA 1601 Cananaro Ct. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes A No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 KNo Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Sheet Metal Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Zoe Hanley John Bordes ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1601 Cananaro Ct. Annapolis, MD 21409Michelle Bordes Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 5/27/2009 Glen Burnie, MD Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Day Annapolis, MD 21401 12 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or the art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** GLIOBLASTOMA MULTIFORME disease or condition resulting in death) 4EARS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) death certificate be executed Exami Due to (or as a consequence of): burial-Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.0. the 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown certificate has been signed by I rector, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 1 ☐ Yes To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) \( \text{HOSPICE} \) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident (Month, Day, Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. To the I within 2 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number MAY 22, 2009 064395 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 N CHARLES ST, SUITE 209 BALTIMOREIND 21204 DOBERMAN, MO 32. Registrar's Signatur State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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		I- For State Registrar		Ce	rtifica	te of l	Death			Re	eg. No.		
Physicia Medical Examir	n/	1. Decedent's Name (First, Midd Raymond W. Bu								Date of Dea Month May 30, 2	Day	Year	3. Time of Death 2150 hrs
		4a. Facility Name (if not institution Fort Washington Hos		nber)		4b	. City, Town, or L Ft. Washingt		Death			nty of Death e George	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birth	day)	If Under 1 Year Months Days	If Under	24Hrs. Min.		,	YYY) 9. Bir Foreig	thplace (State or
Director		218-36-9112	1 X M 2 F		69	Yrs.	Months Days	Hours	IVIIII.	10/14	/ 1939	Co	ountry) WV
any	ł	Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town o	r Location	n						10d. Inside City Limits
<b>*</b>	Ы	MD Princ	e George's	Fo	rt W	ashi	ngton						1 X Yes 2 No
Maryl r 28a-1	rect	10e. Street and Number		<u> </u>			10f. Zip Code			1	0g. Citizen of		ntry?
h with the ims 23a o	a D	1204 Palmer Ro	ad 12. Was Dece	dent Ever in I	ie T	13 Was	20744 Decedent of Hisp		2 / Spec	ify Vas or No		USA	ican Indian, Black,
leath w	Funeral Director	1 Never Married 2 M			J.G.		s, specify Cuban,					Vhite, etc.	roan malan, broom
after d	by F		vorced If Yes, Give Year or Dates:	-			res 2 X No				Spec		ack
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336 thin 72 ne. than	Completed	12	2		Co	ntro	1 Room C	)perat	tor		Elec   Util	tric/ ity 0	Company
5-0( lled wi Hygier I other		17. Father's Name (First, Middle	, Last)					8.Mother's	Name (F		Maiden Surna	ame)	
21215-0036 nuld be filed within 7 Mental Hygiene. marked other than c event, the Medica	o Be	James L. Bund  19a. Informant's Name/Relations			10h	Mailing	Address (Street			annon	nher City or	Town State	a Zin Code)
MD 2 shou th and M 127 is n		Christopher S.		L		_					-		MD 20745
re, rand Frealt Frealt Free		20a. Method of Disposition  1 X Burial 2 Crematio		20b.	Place of		on (Name of cem			Date			r Town, State
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		4 Sonation 5 Other S	is and			•	National	1 (			Laur		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	ĺ	21. Sign ture of Funeral Service	Ligensee	0		1	me and Address	·-					Services
Physician	-	23a. Part I. Enter the disease, of		used the deat	h. Do not	enter the	00 Allent mode of dying, s	COWN such as car	Kd., diac or re	Camp espiratory arr	est, shock, o	rheart	Approximate Interval
/Medical		failure. List only one cause Immediate Cause (Final disease	77	nsive	athe	rosc	lerotic	cardi	iova	scular	disea	ıse	Between Onset and Death
, sammer		or condition resulting in death)	Due to (or as a										
	힐	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence	of):								
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8760, tificate be ng physic as the bur		IF FEMALE: 23b. Was decedent pregnant in t		utcome of pre rth	gnancy 2	Feta	il death 3	Ectopic	oregnand	у	23d. Dat Mon	te of delive th	ry Day Year
Box 6  death cert the attending ed for use a	Physicia	past 12 months?  1 Yes 2 No 9 Un	known	ant at time of d		Othe	er (Specify)						
that the de red by the detached f		Part II. Other significant condi	9 UIKIIQ		resulting	in the un	derlying cause gi	iven in Part	t I.	23e. Did t	obacco use o	contribute to	the cause of death?
, P.O. res that the signed by be detach	a P	Diabetes mel	litus							1 Ye	s 2 No	3 Pro	obably 4 V Unknown
ords,	Completed									24a. Was auto	osy	prior to	utopsy findings available completion of cause of
Reco	Ē										rmed? 2 No	death?	res 2 No
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medica examiner?	Hospital: 1 ✓ In		7			of Death (C				• 00	
n of Vital Records, ling Physician: The law require. . After this certificate has been si funeral director, page 2 should t	의	1 Yes 2 No 27. Manner of Death	28a. Date of (Month,			tpatient ime of Inj		y at Work?		Home 5 8d. Describe	Residence how injury or		er:
Sion ( Attending death. ector: Af	Certification:		ding	Day,Year)		·	1 Y	es 2	No				
Division al or Attendi s after death. al Director:	<u> </u>	3 Suicide 6 Cou	Id not be	of Injury - At I	home, far	m, street	, factory, office bu	uilding, etc.	. 2	8f. Location (		umber or R	tural Route Number, City
Divis Hospital or A 24 hours after Funeral Dire		4 Homicide	ermined (Specify)						_				
the Ho hin 24 the Fu	Medical	(Check only   Certifying P	hysician: To the best aminer: On the basis o	f examination	dge, deat and/or in	th occurre vestigation	ed at the time, dat on, in my opinion,	te and plac death occi	e, and di urred at t	ue to the cau he time, date	se(s) and ma and place, a	inner as sta and due to t	ated. the cause(s)
To viti	ĕ	29b. Signature and title of certification	and manner sta er	ated.			29c. License	number	-		29d. Date	signed (M	onth, Day, Year)
		lanberle	m)				O.C.N	Л.E.			June 3,	2009	
2		30. Name and address of person Laron Locke MD. A	who completed cause Assistant Medical			Penn	Street Baltim	nore MF	2120	1			
Sta	ite								- 120				
Regist	ar	31. Date filed (Month Day Year)	Deneur	gistrar's Signa	acks								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Vear Month 2:30A M **Physician** Marlene F. Brooks May\_ 23rd 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner Prince George Hospital Prince George Cheverly 9. Birthplace (State or Foreign DC 8. Date of Birth (Month, Day, If Under 24 Hrs. 5. Social Security Number 6. Sex If Under 1 Year 7. Age (In vrs. last birthday) Funeral Year) Months Days Hours Min. 1 ☐ M 2 🕱 F Yrs 579-44-9894 09/09/1933 Director Usual Residence of Decedent 10d Inside City Limits 10h. County 10c. City. Town or Location 10a State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examination ust be notified at Md Prince George Director Upper Marlboro 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12800 Cambleton Drive 20774 USA Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates: Black, White, etc. 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Gov't 2vrs Budget Analyst 12 should be filed wi h and Mental Hygier **7 is marked other tt** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Neal Edna Butler ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20774 Health a Robert M. Brooks(husband) 12800 Cambleton Drive Upper Marlboro Md other t permit. Pages 1 and Department of Heal Important: If item 2 any Injury or other 3altimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Nat Cem May 30,09 Laurel Maryland 4 ☐ Donation 5 ☐ Other (Specify) f Funeral S 22. Name and Address of Facility 20011 Tyrone J. Young 719 Kennedy St. NW WashDC 23a. Part 1. Enter the disease, or c shock, or neart failure. Listed mplications that caused the deal had one a se on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed and Due to (or as a consequence of): burialphysician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☒ No ed by the 9 I I Inknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Was a.. autopsy performed? 24a. Was an page 2 s has certificate 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural 5 Pending

Box 68760, P.O. Records,

Hospital or Attending Physician: The Division of Vital Certification: To death. hours after death.
uneral Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) the Funeral Direct 4 Homicide Medical 29a, Certifier 1 🛛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr.Tsion Berhane 3001 Hospital

Drive Cheverly Md. 31. Date filed (Month, Day, Year) 32. Registrar's S

Registrar

19055703

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 20a-c, per FH 9893 7/15/09 TT

State of Maryland / Department of Health and Mental Hygiene 6-3-09 For 6-3-09 State Registrar Amend#23e.PenPhys.PGCcr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2009 **Physician** May 24, Olivia Bolden 0115 M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Joseph Richey Hospice Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | Feb. 26, 1948 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 XF 579-80-5307 61 Yrs. **Director** unk Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Wedical Examiner is ust be notified at 1√Yes 2 No Directo MD Prince Georges Oxon Hill 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1100 Owens United States Road Completed by Funeral 20745 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ñ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: Black 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ould be filed within I Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 House Wife Private Item 27 is marked other other traumatic event, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Osburn Arlene Hall Pages 1 and 2 should I ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra 3157 Elmora Ave., Baltimore, MD 21212 Thomas Hall - Son Baltimore, 20c. Location - City or Town, State
Riverdale, MD Suitland, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 7/13/2009 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Park Crematory 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, MD.20746 21. Sign Mare of Funeral Service Licens 23a. Far 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiclan disease or condition resulting in death) 2 MOS UNG /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Unsease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-tran and Due to (or as a consequence of) physician the death certificate be Physician/Medical as Box IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 

Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached o 9 Unknown 9 Unknown ۵. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Records, 4 Onknown OBSTRUCTIVE PULMOWARY 1 ☐ Yes 2 🗆 No 🛥 Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an HYPOTHYROIDISM has autopsy this certificate 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) HOSPICE 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To ot completely filled in by the funeral 27, Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Division 5 ☐ Pending investigation 1 □Yes 2 □ No death. s after death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Hospital 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. VILUNTEER 29d. Date signed (Month, Day, Year) 29c. License number PHYSICIAN DOB26327 4 CAMPARE, COLUMBIA, MD 21045 State Registrar

24/2059

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DIED

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Alfred Wallage Butler 1100A M Ma 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death PGP. G. Comunity Hospital Cheverly 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 220-62-8549 1**X** M 2 □ F 54 Maryland 08/19/1954 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No  $\mathbf{R}$ Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5401 Topedka Avenue 20743 **UEA** 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Never Married 2 ☐ Married Specify: Black If Yes, Give Year or Dates: 1 □Yes 2 XNo 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 2 VEALS Self Employed Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen Brown - Butler Samuel Wallace 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 516 60th Place, N.E. #202; Washington, D.C. 20019 Carl D. Butler - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 05/29/2009 Beltsville, MD Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Freeman Funeral Services 21. Signature of Funeral Service Licenses 4594 Beech Road; Temple Hills, MD 20748 23a. Part 1. Enter the disease, or com/ lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ntra Crania Due to (or as a consequence of): PSIS Sequentially list conditions Due to (or as a consequence of) if any, leading to immedic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23d. Date of delivery ent pregnant 2 months? Month Year ≥□No

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

10a. State

MD

**Funeral** 

**Director** 

28a-f show

Director

Funeral

þ

Completed

Be

ortant: If item 27 is marked other than "natural", or Items 23a or 28a-f shov injury or other traumatic event, the Medical Examinar must be notlified at

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature!" any injury or other transes.

Baltimore, Maryland 21215-0036

or Attending Physician: The law requires that the death certificate be executed

sician and burial-trans

Records, P.O. Box 68760,

Division of Vital

death.

24 hours after death Funeral Director: Hospital

completely within 2

Examine Physician/Medical à Completed Be Medical Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ ∀es 2 □ No 9 □ Unknown	d.  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)
The second secon	ns contributing to death but not resulting in the Remail DISEC	

23c.	If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown

3 ☐ Ectopic pregnancy 5 ☐ Other (specify)

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24h Were autonsy findings available

		autopsy prior to completion of cause of death?  1 □Yes 2 □No 1 □Yes 2 □No
25. Was case referred to medical	2	26. Place of Death (Check only one)
examiner? 1 ☐ Yes 2 ☐ No	Hospital: Phinpatient 2 ER/Outpatient 3 DOA	Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death  1. Natural 5 ☐ Pending 2 ☐ Accident investigation	m M 11	njury at 28d. Describe how injury occurred fork? □Yes 2□No
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		e 28f. Location (Street and Number or Rural Route Number, City or Town, State)
		e time, date and place, and due to the cause(s) and manner as stated.

29b. Signatu	re end title	of certifier	)	7
	-			
30 Name an	d addrage	of person W	The second	cause of de

29c. License numbe D5533

29d. Date signed (Month, Day, Year)

ath (Item 23a) (Type, Print)

3001 H 31. Date filed (Month. Day, Year)

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2009 3:40 A M May 27 Shirley L. Boyd 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Frederick Citizens Care and Rehabilitation Ctr. Frederick If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Days 1 □ M 2 1 F 1934 Maryland 6, 577-44-9857 Usual Residence of Decedent 10d Inside City Limits 10b. County 10c. City, Town or Location 1 X Yes 2 □ No Maryland Prince Georges Lanham 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20706 U.S.A. 9220 Fowler Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Lanham United Elementary/Secondary (0-12) College (1-4or 5+) Methodist Church Secretery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Minnie Sauberlich Russell Lynn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1110 Iron Springs Rd. Fairfield, PA. 17320 Gwen Courtney (daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery Bladensburg, MD. 4 ☐ Donation 5 ☐ Other (Specify) 6/1/09 22. Name and Address of Facility 21. Signature of Funeral Service Licens Rendon/Hale Funeral
9013 Annapolis Rd. Lanham, MD 20706
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line. Rendon/Hale Funeral Home Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequent e of): At traic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Dav 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐No 2 **N**o 1 □Yes 26. Place of Death (Check only one)

/Medical Examiner law requires that the death certificate be executed and burial-trar Box 68760, attending physician for use as the buria the as use a P.0. signed by the Division of Vital Records, cate has t page 2 s certificate the Hospital or Attending Physician: this After 1

**Physician** 

Examiner Physician/Medical à Completed Be Certification: To death.

**Physician** 

/Medical

Examiner

10a State

Director

Funeral

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Completed

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12

**Funeral** 

Director

show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, It is Medical Examiner must be notified at

3altimore, Maryland 21215-0036

24 hours after death. Funeral Director: A etely filled in by the fu 24 hours 2

Medical State

Registrar

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? Hospital: Other: 1 | Yes 2 | 1 | N 2 ER/Outpatient 3 DOA 4 ☐ Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🔲 Inpatient 28b. Time of Injury 27. Mann Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Whatural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number

Dr. Frederick MD 21702

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

31. Date filed (Month, Day, Year) MAY 2 8 ZUUS

29b. Signature and title of certifier

29a. Certifier

(Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month Breidenbach Robert Melvin 11520 5 2009 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death WICOMICO SALISBURY COASTAL HOSPICE AT THE LAKE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Numbe 7. Age (In yrs. last birthday Date of Birth (Month, Day, Year) Days Hours 80 218-22-6854 1**x** M 2 □ F Yrs 07/25/1928 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Wicomico Salisbury Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21804 USA 915 W. Schumaker Manor Dr. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) police officer law enforcement 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mildred E. Caulk Paul L. Breidenbach 19a. Informant's Name/Relationship (Type. Print)
Lorraine E. Breidenbach/wife 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) 915 W. Schumaker Manor Dr., Salisbury, MD 21804 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 5/26/09 Salisbury, MD Salisbury Crematory 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Compron CFSP Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) -Stage sase Due to (or as a contequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or in a consequence of) Due to (or as a consequence of): 23d. Date of delivery Month Day Year se contribute to the cause of death?

29d. Date signed (Month, Day, Year)

**Physician** /Medical Examiner

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 Is marked other thi any injury or other traumatic event, it a. once.

Examine the Hospital or Attending Physician: The law requires that the death certificate be executed

**Physician** 

/Medical

Examiner

Director

Funeral

<u>و</u>

Completed

Be

2

**Funeral** 

Director

'natural', or items 23a or 28a-f show the Medical Examiner must be notified at

death with the Maryland

filed within 72 hours after

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760

BreibeNbach

attending physician and for use as the burial-trar signed by the a cate has l this certificate half Director: d in by the

Physician/Medical

≥

Completed

Be

Certification: To

Medical

29a. Certifie

29b/Signati

Name Ind

31. Date filed (Month, Day, Year)

(Check only

After

thin 24 hours aft the Funeral Di mpletely filled in

within 7

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1	23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	3e. Did tobacco use contribute to the cause of death?  1 □ Yes 2 □ No 3 □ Probably 4 □ Unknown
		4a. Was an autopsy performed?  □ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
25. Was case referred to medical	26. Place of Death (Che	ck only one)
examiner? 1 ☐ Yes	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5	□ Residence 6 Other (Specify) 1050[CE
27. Manner of Death  1 Natural 5 □ Pending 2 □ Accident investigati	on (Month, Day, Year) Injury Work?  M 1 ☐ Yes 2 ☐ No	escribe how injury occurred
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	286. Place of injury - At home, farm, street, factory, office 28f. Lo	ocation (Street and Number or Rural Route Number, ity or Town, State)

death (Item 23a) (Type, Print)

and manner stated.

address of person who completed cause

State Registrar ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 decical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

10a Sta

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | 1 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Month **Physician** 02, 7:40 P M Charles Victor Clingerman June /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington 12530 Seavolt Road Hancock Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 XM 2 ☐ F 80 Yrs. 214-28-1142 1928 WV Director Usuel Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County ir than "natural", or Items 23s or 28s-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2X No Director MD Washington Hancock 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 12530 Seavolt Road 21750 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. hours after 1 XYes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖫 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NDT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 I Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "nat any Injury or other traumatic event, the Mealts any Injury or other traumatic event, the Mealts Elementary/Secondary (0-12) College (1-4or 5+) Assembler Parts Remanufacture 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Jesse Clingerman Flo Vann 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12530 Seavolt Road Hancock, MD 21750 Naomi M. Clingerman/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 06/05/2009 Needmore, PA \* 4 □ Donation 5 □ Other (Specify) Tonoloway Baptist 22. Name and Address of Facility 141 West Main Street 21. Signature of Funeral Service Licensee Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician HYPERTENSION disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner DIABETTS, TYPEZ Sequentially list conditions, if any, leading to immediate cause (Disease or injury Due to (or as a consequence of): Examiner certificate be executed as the burial-transit HEART DISEASE CARONARY iding physician and that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical ONGESTIVE HEART FAILURE IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) 4☐Pregnant at time of death ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 2 No 1 🗌 Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: To the Hospital or Attending within 24 hours after death.

To the Funeral Director; After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State

Rowrence Hornick MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Lawrence Hornick, M.D. 130 West High Street Hancock, MD 21750 32. Registrar Signature

Registrar

29c. License number

D 0066 751

29d. Date signed (Month, Day, Year)

6/3/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 5:22 pm **Physician** Hyekyung Cho 2009 19, May /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Min 1 M 28 F Korea South 10/30/1987 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Ext. in the matter must be a citied at once. 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 ☐ Yes 2 No Camino Viejo de Llubi Director Inca Spain 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number South Korea 07300 Apartado de Correos 338 Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Tes 25 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Asian <u>م</u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) College Student 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Oklea Park Cho Young Hwan ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Apartado de Correos 338 Inca, Spain 07300 Oklea Park, mother 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Sremation 3 ☐ Removal from State Chesapeake Crematory 5/28/2009 Beltsville, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Svcs. 933 Gist Ave. Silver Spring, MD 20910 u 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 1410 disease or condition resulting in death) /Medical Due to (or sa consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Uncerlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

24 hours after death.

Puneral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 □ Yes 2 No 25. Was case referred to medical examiner?
1 Yes 2 □ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 X ER/Outpatient 3 □ DOA 1 Inpatient Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 1 🗌 Natural 5 Pending investigation Self-Inflicted 600 1 Yes 2 2 No Meh 12 5003 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rura Floute Number, City or Town, State) 205 EVG-95 3 Suicide 4 ☐ Homicide At home, farm, street, factory, office determined 4017 HOm Rock UILE MO 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier mo DME

State Registrar moomE

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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BREC

28

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Yo1anda Chok 11:38p May 23, 2009 4b. City, Town, or Location.
Silver Spring 4c. County of Death

Montgomery 4a. Facility Name (If not institution, give street and number) Town, or Location of Death Homecrest Assisted Living Facility 8. Date of Birth (Month, Day, Year) Nov. 8, 1911 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Social Security Number 6. Sex 9. Birthplace (State or Foreign 1 □ M 2 🔽 F Months 577-03-1014 97 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Silver Spring Maryland Montgomery 1 ☐ Yes 2 🔀 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1400 Ferwick Lane. #408 20910 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕱 No Specify: White 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Clerical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Angelo Scocca Angelina Cook 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jill S. Parreco/Personal Rep. P.O. Box 60404, Potomac, MD 20859-0404 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State May 27, 4 □ Donation 5 □ Other (Specify Metropolitan Crematory Alexandria, Virginia 2009 21. Signature Funeral Service 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd., W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part 1 the rise disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Aortic Stenosis disease or condition resulting in death) 1 year Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 2 🗆 No 1 TYes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Assisted 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Living 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

**Physician** /Medical Examiner

Box 68760

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Division of Vital Records,

Physician:

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Physician/Medical

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completely

To the Hospital or within 24 hours a To the Funeral D

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

Director

Funeral

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Completed

7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, Inc Modical Examinar must be notflied at

with the Maryland

within 72 hours after death

filed within Hygiene.

s 1 and 2 should be fil f Health and Mental H tem 27 is marked oth

of Health

þ permit. Pages Department of Important: If it any Injury or o

Baltimore, Maryland 21215-0036

sician and burial-transit physician sthe burial use as ō signed by the and be detached for been s certificate has b irector, page 2 s director this

requires that the death certificate be After thi funeral Hospital or Attending death. after death Director:

25. Was case referred to medical

29a. Certifier (Check only one) 29b. Signature and title of certifier

D33159

May 27, 2009

1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ruth Kevess-Cohen, MD 8700 Georgia Avenue, Silver Spring, MD 20910

Registrar

31. Date filed (Month, Day, Year) MAY 28 2009



2 Accident

4 Homicide

29b. Signature and title of certifier

3 Suicide

29a. Certifier

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

, or items 23a or 28a-f show

Director

Funeral

Be Completed by

မ

Examine

Medical Certification: To Be Completed by Physician/Medical

Department of Health and Mental Hygiene. Important: or items 23a or 28a-f show amy injury or other traumatic event, It = I edical Evaruing must be notified at once.

For State Registrar		O.a.o c	of Marylan		rtificate of				g. No.	2000	1979
. Decedent's Name (I	First, Middle Farrel		_					2. Date of Death Month	Day	Year	3. Time of Death
valles	rarrer.	- Clark						May 25,	20		7:55 PM
a. Facility Name (If no	ot institution,	, give street and nu	ımber)		4b. City, Town,				4c. C	County of Deat	h
12805 Little			,			er Spr	-		i	Montgome	
Social Security Num 578–36–1152		6. Sex 1	7. Age (In yrs.	last birthday, <b>79</b> 7rs.	Months Days		Min.	8. Date of Birth (Month, Day,  Jan. 6, 1		Co	hplace <i>(State or Foreig</i> untry) <b>Mississippi</b>
ual Residence of De	ob. County		10c Cit	y, Town or Le	ocation						10d. Inside City Limits
faryland		ontgomery	100. 01	Silver							1 □Yes 2 <b>K</b> No
e. Street and Number	er				10f. Zip Code			10		en of What Co	untry?
12805 Lit	ttleton	Street			20	906			1	USA	
Marital Status		12. Was Dec	edent Ever in U.	S. 13.	Was Decedent of	Hispanic C	rigin? (Sp	ecify Yes or No-	1-	4. Race - Ame Black, White	
1 Never Married	<b>2</b> ™ Marri	ed 1 XYes	2 No		1 ☐ Yes 2XXV			Triodii, oto.)			
3 Widowed 4	Divorced	If Yes, G Year or I	oates: 1952-	58	ILLIES CAMPA	s specin	у.		'	Specify: Whi	te
(Specific	5. Decedent	's Education t grade completed,	)	16a. Dece	edent's Usual Occ	upation	net of work	ina 1	6b. Kin	d of Business/	Industry
Elementary/Seconda		1	(1-4or 5+)	life.	DO NOT use retir	red)					
12	-,,		- /	S	heet Metal	Specia	alist	S	neet	Metal	
Father's Name (Fir						18. Moti	her's Nam	e (First, Middle, M	a <i>iden S</i>	Gurname)	
Clyde Farm	cell Cla	ark				Man	garet	Clower			
a. Informant's Name Karen Clark  a. Method of Dispos  1 3 Burial 2 0  4 0 Donation 5	Rios/I	Daughter 3 🗆 Removal from	State	20 M		venue,	Silve	ral Route Number, or Spring, I Date 2 May 29,2009	MD 2	0901 eation - City or	
. Signature of Fune				2	2 Name and Add Francis J.	ress of Fac	ns Fun	eral Home	Inc.		
X plee:	1/.	1/5	~ こ					, Silver S		g, MD 209	01
3a. Part 1. Enter the	disease, or	complications that	caused the deat								Approximate Interval Between
nmediate Cause (Fir		only one cause on	_								Onset and Death
sease or condition sulting in death)	3	a	estive Hea		ure					_	
	1		(or as a conseq	,							
equentially list condi	tions,	D	ary Artery (or as a conseq		se						
ause. Enter Underlyi ause (Disease or inj	ing 🚤	\$ 200.00	,	5./.							
at initiated events sulting in death) Las		C	(or as a conseq	uence of).							
			( as a consoq	01/1							
		d									
FEMALE:  Bb. Was decedent pr in the past 12 mo 1  Yes 2 N 9 Unknown	onths?	1 Live	utcome of pregnation 2 Teta birth 2 Teta gnant at time of a cnown	ıl death 3	☐ Ectopic pregna ☐ Other (specify)				2	3d. Date of de Month	livery Day Year
								One Did tob		o contributo t	o the cause of death?
rt II. Other significa	ant conditio	ns contributing to	death but not res	ulting in the i	inderlying cause (	given in Pari	t 1.				robably 4 Unknow
								24a. Was an		24b. Were a	utopsy findings availab
								autopsy	/	prior to death?	completion of cause of
									<b>X</b> No	1 ☐ Yes	s 2 No
. Was case referred examiner?		Magnit-1					ce of Dea	th (Check only one	)		
1 Yes 2 No	)		Inpatient 2		III JU DOA		Nursing H	ome 5X Reside	nce 6	□Other (Spe	ecify)
7. Manner of Death	5 Pending	28a. Date	e of Injury nth, Day, Year)	28b. Time	of 28c. In	jury at ork?		28d. Describe hor	w injury	occurred	

28f. Location (Street and Number or Rural Route Number, City or Town, State)

0910

29d. Date signed (Month, Day, Year)

To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar s been signed by i should be detach cate has t this certificate within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral

> State Registrar

31. Date filed (Month, Day, Year) MAY 28 2009

1400 Forest

6 ☐ Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ra Glen Registrar's Signat

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

911

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner example.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year  $\mathbf{P}^{\mathsf{M}}$ **Physician** MAY 31, 5:25 2009 EDWARD GUY CARMEL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner WASHINGTON HAGERSTOWN RAVENWOOD LUTHERAN VILLAGE Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 4, 1935 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min 1**X**M 2□ F Pennsylvania 74 206-26-5471 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State r items 23a or 28a-f show iner rust be notified at 1 ☐ Yes 2 Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with USA 21740 10918 Allen Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? VAYes 2 □ No 1958-If Yes, Give Year or Dates: 1960 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene. ant; if item 27 is marked other than "natural", or ifter ury or other traumatic event, it is Medical Examina-1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√√No Specify: White Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Truck Manufacturer Supervisor 18. Mother's Name (First, Middle, Maiden Surname) Be ( 17. Father's Name (First, Middle, Last) Guy Arthur Carmel Agnes Marie Johnson 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 149 Mill Creek Dr. Charlottesville, Virginia 22902 Rebekah L. Carmel - Daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If it any injury or conce. 1 ☐ Burial 2XX cremation 3 ☐ Removal from State Smithsburg Crematory June 1,2009 Smithsburg, Maryland 5 ☐ Other (Specify) 4 Donation OSBOTTE ATTEMETED Home, P.A. 21. Signal 425 S. Conococheague St. Williamsport, MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Ouse also Immediate Cause (Final coronall Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): unicoru Examiner Sequentially list conditions, if any, leading to financiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last During for as a consequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 □ Yes 2 □ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1XYes 2□No 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Other: 4 🛮 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No ithin 24 hours after death.

the Funeral Director: A pmpletely filled in by the fu 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 611 10066116

2H-10+1 State

A11 368 MILL JUN 02 32. Registrar's Signature

Andaleeb

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

parke

TREET, Hegerstown,

Registrar

DHMH 17 Rev 1/2001 OCME 2006

State Registrar 32. Registrar's Signature

**ORIGINAL** 

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10 US A /Medical County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Randalls Low I.

H Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | (Month, Day,
Jan. 12, Baltimore Seasons Hospice 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F 60 1949 577-66-6779 Yrs Jan. Director Usual Residence of Decedent Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evaniner must be notified an once. 1 X Yes 2 No Riverdale Director Prince George's Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6609 Greenvale Parkway 20737 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 █ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black. African 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 📉 No Specify Specify: American þ 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+ Postal Clerk Government 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Riddick Alice Minter ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7201 Cross Street District Hgts., MD 20747 Donald M. Williams/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place Harmony Memorial Park 20c. Location - City or Town, State Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 30, 2009 May Landover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Rd. N.E. Washington, DC 23e Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BLADDER Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 DNo Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐Yes 2 ☐No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOS DICE 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No in by the 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Dimedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated To the within 2

State Registrar

29b. Signature and title of certifie

use of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - For State Registrar	State of Ma	Ce	rtificate of		•	Reg. No 200	9 18786			
Physic	eian	1. Decedent's Name (First, Middle, La	st)				2. Date of Dea Month		3. Time of Death			
/Med	ical	Genoveffa Cook		May		009   3:20 a M						
Exami	iner	4a. Facility Name (If not institution, given 204 Birch Court	e street and number)	,	or Location of Death	4c. County of Death  Anne Arundel						
Funera		5. Social Security Number 6. S		(In yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birt (Month, Da		Birthplace (State or Foreign Country)			
Directo	r	210 02 2333	□ M 2 <b>X</b> F	79 Yrs.	World's Days	Hours Will.	May 26	, 1929	Italy			
land bw		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits										
Mary t-f sh	tor	MD Anne A	rundel	Severn	a Park				1 □Yes 2 🙀 No			
th the	Director	10e. Street and Number	J.		10f. Zip Code			10g. Citizen of Wha	at Country?			
ath w	rall	204 Birch Court				21146			USA			
ter de items	Funeral	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married		ver in U.S.	If Yes, specify Cuban, Mexican, Puerto			14. Race - Black,	American Indian, White, etc.			
NU36  ours after death with the Marylan ral", or items 23a or 28a-f show Examiner mast be rediffed at	þ	3 ☑ Widowed 4 ☐ Divorced		1 □Yes 2 X No	Specify:		Specify:	White				
Q Z1Z13-UU3B filed within 72 hours after death with the Maryland Hygiene. wher than "natural" or items 23a or 28a-f show ont, the Modical Experience must be redified at	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	(Give	dent's Usual Occu	during most of worki	na	16b. Kind of Busin	ness/Industry			
Z1Z15-U within 72 ho giene. r than "natur	I di	Elementary/Secondary (0-12)	College (1-4or 5-	DO NOT use retire	NOT use retired) Homemaker			Home				
filed v Hygic		17. Father's Name (First, Middle, Last	)		HORICHE	18. Mother's Name	(First, Middle,	Maiden Surname)	none			
Viand  Vid be file  Mental Hy  arked oth  attic event	To Be	Antonio Cernogora	az			Amalia	Naperot	tich				
ire, Maryland 7 s 1 and 2 should be filed of Health and Mental Hygitem 27 is marked othe other traumatic event,	-	19a. Informant's Name/Relationship (		I .	-	and Number or Rura						
and 2 and 2 lealth m 27		Ann Amalia Dean/Da	aughter		4 Birch (			rk, MD 2				
0 0 - =		20a. Method of Disposition 1 ABurial 2 ☐ Cremation 3 ☐		20b. Place of Dispo cemetery, cre		<sup>ce)</sup> Ma	y 27, 009	20c. Location - Ci	•			
<b>Daltim</b> permit. Pag Department Important: I any Injury o		4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lices		Maryland					ville, MD			
Depariment of the police.		Thouse	PL	Bi	arranco 8 95 Gov. F	Sons, P. Ritchie Hw	A. Sev y. Sev	erna Parl erna Parl	K Funeral Home K, MD 21146			
		23a. Part 1 Enter the disease, or com shock, or heart failure. List only	plications that caused tone cause on each line	the death. Do not en	ter the mode of dyi	ng, such as cardiac o	or respiratory ar	rest,	Approximate Interval Between			
Physician		Immediate Cause (Final disease or condition resulting in death)	a Breast Cancer						Onset and Death  24eurs			
/Medical Examiner		1	Due to (or as a	consequence of):								
	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	o (or as a consequence of):								
ecuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	С									
be exe	Ä	resulting in death) Last	Due to (or as a consequence of):									
oo / ou, ificate be e) g physicien is the burial	Medical		d									
ath certii	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					23d. Date	23d. Date of delivery			
death	Physician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown		」Ectopic pregnand ☐ Other (specify) _	Ectopic pregnancy Other (specify)			Month Day Year			
at the	Phys	9 Unknown										
ires th	þ	Part II. Other significant conditions of	_	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☑ 100 3 ☐ Probably 4 ☐ Unknown								
v requires to been signer should be	etec	TIGRETTON	2101						-			
he law e has	Completed						24a. Was autop	sy prid	re autopsy findings available or to completion of cause of ath?			
vital ician: T sertificat ector, pa	(a)	25. Was case referred to medical 26. Place of Death (Check only one)										
Physici Physici This cerral direc	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatier	nt 2 ER/Outpatie	nt 3 DOA Oth	or.		dence 6 ☐ Other	(Specify)			
ing P	no ::	27. Manner of Death 1 □ Matural 5 □ Pending	28a. Date of Injury (Month, Day)	y 28b. Time o Year) Injury	Wor	k?	28d. Describe h	low injury occurred				
ttend death ctor: /	icati	2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide 1 Homicide 1 Accident 2 Accident 3 Suicide 4 Homicide 2 Accident 3 Suicide 4 Homicide 2 Accident 3 Suicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 2 Accident 5 Accident 6 Homicide 1 Accident 7 Accident 7 Accident 8 Accide										
after after Direct din by	Certification:	4 ☐ Homicide determined	building, etc.	<ol> <li>Location (Street and Number or Rural Route Number, City or Town, State)</li> </ol>								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicien end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier  (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)										
o the ithin 2 the omple	Medical	29h Signature and title of certifier 29c License number							29d. Date signed (Month, Day, Year)			
⊢ s ⊨ ō		Duralio	6389			ay 22, 2009						
ISCAL	-	30. Name and address of person who		ath (Item 23a) (Type,	Print)	1, Balf						
	ate	31. Date filed (Month, Day, Year)	32. Pegistrai		, silau	, isalt	THOVE	2(	202			
Regist	rar	MAY 27 2	009 Sener	UB.	ark							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** rump 2009 Morgan Oe 21 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Arundel Annapolis Anne Medical Center Arundel Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 4(North, Pay Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 XF Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director Springdale Prince Georges Md 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or items 23a or: Endicott Place US 20774 3701 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Black δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Shandra Crump Oneal Harrison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 3701 Endicott Place Springdale MD 20774 Father David Crump 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State 5/27/09 Glen Burnie,MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Incenses 12 Ridgely Ave Annapolis, MD 21401 Hardesty Funeral Home P.A. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical Due to or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and is detached for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE ves, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 Yo 3 ☐ Probably 4 ☐ Unknown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the lirector, page 2 s autopsy performed? 1 □ Yes 2 🗷 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1-Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Medical

24 hours after death.

Funeral Director: After this certificetely filled in by the funeral director, within 24 hor To the Fune completely fi

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

30. Name and a cross of person who completed cause of death (Item 23a) (Type, Print) Susan Rindfleisch

Anne Arundel Medical Center Annapolis,MD

State Registrar 31. Date filed (Month, Day, Year) 27

Registrar's Signature

			Plea						c. Ensure A		_	le.		
			For State Registrar	State	ot ivia	ryian		ertificate of	Health and I Death		iene <sub>eg. No.</sub> 2	19	18788	
	Dhuaisi		Decedent's Name (First, Middle							2. Date of Deat	h Day	Year	3. Time of Death	
	Physicia /Medic	al	Princert	E				_	Chapman  4b. City, Town, or Location of Death		23 20 4c. County o		1710 M	
	Examin	er	4a. Facility Name (If not institution Anne Arundel Me					Annapo		1	Anne A		le1	
ı	Funeral Director		155-30-6332 ¹\\ ™ 2□F				e (In yrs. last birthday) If Under 1 Y				Year) 33  9. Birthplace (State or Foreign Country) Denver CO			
5-0036 72 hours after death with the Marvland	/land		Usual Residence of Decedent  10a. State 10b. County			10c. Cit	y, Town or l	ocation.				1	0d. Inside City Limits	
	e Mary Sa-f sh	Director	MD Anne Arundel			Odenton						1 □Yes 2 No		
	172 hours after death with the Marylar "natural", or items 23a or 28a-f show efter Econinar must be notified at	To Be Completed by Funeral Dire	10e. Street and Number 1014 Samantha Lane			10f. Zip Code 21113			1	10g. Citizen of What Country? USA				
	death		11 Marital Status 12. Was Decedent			Ever in U.S. 13.		. Was Decedent of	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto Ri		14. Race		can Indian,	
36	s after ; or ite		Armed Forces?  1 □ Never Married 2 ☑ Married 1 ☐ Yes 2 □ If ♣es, Give  3 □ Widowed 4 □ Divorced Year or Dates:		s 2 □ N Give	No		1 □Yes 2 □ No		o nican, etc.)	Specify:	lack, White, etc. Cify: White		
1215-0036	2 hour		15. Decedent's Education			16a. Decedent's Usual Occupation (Give kind of work done during m			upation			6b. Kind of Business/Industry		
			(Specify only higher Elementary/Secondary (0-12)	ī	e (1-4or 5-	+)	life.	DO NOT use retire	ed)	king	U.S. A	in T	·	
_ 3	Hygie Hygie ther nt, t		17. Father's Name (First, Middle,				Senio	r Master		ne (First, Middle, M			orce	
yland 2	should be f nd Mental   marked o		Princert E. Chapman SR. Ruth Holland									ıd		
Mar	is rat		19a. Informant's Name/Relations						at and Number or Ru			State, Zip	Code)	
	1 an Hea em 2		Theresa Cullemb 20a. Method of Disposition	-		20b F	Place of Disi	nosition (Name of	na Lane Oc		21113 20c. Location - C	Dity or To	own, State	
Ë	m 0		14 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		om State			ematory or other pla t Cemeter		09	Davidso	nvil	le,MD	
Baltimore,	permit. Page Department Important: II any Injury o		21. Signature of Furtheral Service	Ligensee			1	22. Name and Addr ardesty I	ress of Facility Funeral Ho	ome P.A.	851 Ann Gambril	apol	is <sub>2</sub> R8ad	
	_		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death									Approximate Interval Between Onset and Death		
14.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Respiratory tail we due to (or as a consequence of):									days		
	Examiner		Sequentially list conditions	b. 5n	rall	al	l li	ng can	ur		- 5/4/4	months		
ted	nsit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence of: of						ue years				
Ď,	be executed cian and ourial-transit		triat initiated events				a consequence of):						1	
		dical		mon	.ia			a ay s						
ROX	death certificate e attending phys d for use as the l	an/Me	IF FEMALE: 23b. Was decedent pregnant is the past 12 months?  23c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal d					B □ Ectopic pregnar	nov	23d. Date of delivery		*		
at the death	t the deal by the att	Physician/Medical	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Dyes 2 No 4 Pregnant at time of death 5 Other (specify)							nth	Day Year		
l Sign	law requires that the di as been signed by the 2 should be detached	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute  1 Yes 2 No 3 P								ibute to t			
Hecord	w requ	Completed	Atrial fibrillation						24a. Was a	an 24b. Were autopsy findings available				
r	The ate h	Som C	Cerebrovascular accident							perfori	autopsy prior to completion of cause of death?  ☐ Yes 2☐ No 1☐ Yes 2☐ No			
VITAI	ician: certific rector,	Be	25. Was case referred to medical examiner?  Light State of Death (Check only one)											
0	g Phys er this eral dii	n: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. D	ate of Injur	У	28b. Time	of 28c. Inj		lome 5 Reside			fy)	
101	ending sath. or: Aftu he fun	atio	1 Matural 5 Pendir 2 Accident investi	gation	Aonth, Day		Injury	M 1[	□Yes 2□No					
DIVISION	l or Att after de Directo I in by t	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc.			ry - At home, farm, street, factory, office 28f. Location (5 City or Tov				28f. Location (S. City or Town	Street and Number or Rural Route Number, wn, State)			
	To the Hospital or Attending Physician: within 24 hours after death, To the Funeral Director: After this certified completely filled in by the funeral director, p	edical C	29a. Certifier  (Check only (Check only 2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)											
	<b>Го the</b> vithin 2 <b>Го the</b>   хоттрев	Med	one) and manner stated.  29b. Signature/end title of certifier					29c. License number 29c			Od. Date signed (Month, Day, Year)			
	LXI	101	D M, mo					,0390	05/26	5/26/2009				
	N/O	Y	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  A DEEB JABER 2001 MEDICAL PKWY. ANNAPOLIS, MO 21401											
	Sta	te	HOEEB JABER 31. Date filed (Month, Day, Year)	3:	2. Registra	ır's Signa	ature		(	1				
	Registr	ar	MAY 27	2009	Energ	,	1. 1	are						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 24 05 2009 Ellen E. Curry /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner JA415BUR OM OASTAL FlOSPICE AT THE If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Months 1 □ M 2√2 F 11, 1926 MD 222-16-2069 82 Director Aug Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examination question notified at 1√2Yes 2□No Funeral Director MD Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21801 630 Arthur St. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 🔀 No Completed by 3 Widowed 4 Divorced Maryland 21215-00 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Board of Education Educator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Otis L. Wilson Elsie Dashield ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type. Print) 630 Arthur St., Salisbury, MD 21801 Harold L. Curry/husband Department of Health Important: If item 27 any injury or other trong once. 27 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Springhill Memory
Gardens 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/01/2009 Hebron, MD 22. Name and Address of Facility Lewis N. Watson Funeral Home, PA 21. Signature of Funeral Service Licenses 1618 West Rd., Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Tage disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ypertensiz Sequentially list conditions bue to for as a consequence of): Physician/Medical Examiner any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed Melli Tabetes burial-tran Due to (or as a consequence of): Box 68760, the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. detached cate has been signed page 2 should be dete Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate has Physician: The 1 Tyes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t Hospital or Attending Natural 5 Pending te Funeral Director: A pletely filled in by the fu 1 ☐ Yes 2 ☐ No death. Investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 🛶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. the within 7 29d. Date signed (Month, Day, Year) 29b Signature and title of contities 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) gmuelle State

DHMH 17 Rev 1/2001

Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** May 25, 2009 7:30 a Emmy Dreyfuss /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Montgomery General Hospital Olney If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 04/27/1912 5. Social Security Number Birthplace (State or Foreign
Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F Months Days Hours Min Germany 97 Director 051-18-0726 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location LIE 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the "Modoal Event increases be notified at once. YYes 2 □ No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20906 USA 15101 Interlachen Drive #412 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 white 1 TYes 21€ No Specify. Specify: à 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Assembly Worker Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kahn Bernard Reinman Anna 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10100 Lloyd Road, Potomac, Maryland 20854 Norman M. Dreyfuss, son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 12 Burial 2 ☐ Cremation 3 ☐ Removal from State Judean Memorial Gdns 05/28/2009 Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature A Funeral Subject Licensee 22. Name and Address of Facility
Edward Sagel Funeral Direction, Inc. 20852 1091 Rockville Pike, Rockville, Maryland Approximate Interval Between Onset and Death 23a. Part F. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on Immediate Cause (Final **Physician** neumound disease or condition resulting in death) ) /Medical Due to (or as a consequence of): Examiner infection tract Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Examine physician and s the burial-transit The law requires that the death certificate be executed Sis Due to (or as a consequence of) Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for Ö 9 Unknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown Completed peen Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy certificate 1 □Yes 2 12 No 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending F Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 🗌 No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title 25 10 30. Name and add person who completed cause of death (Item 23a) (Type, Print) Montgomery General Hospital, Olney, Maryland IN 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAY 28 Registrar

			1 - State of Maryland		artment rtificate			ind Me		jiene eg. No.	09	18791
	Dhuaisi		Decedent's Name (First, Middle, Last)						2. Date of Deat Month	th Day	Yeer	3. Time of Death
	Physici /Medic		Clarence L. Denson III		,				05	24	2009	1235 <sup>M</sup>
*	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, To	own, or	Location of	f Death		4c. Co	unty of Death	
			Holy Cross Hospital		Silve						tgomer	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last		If Under 1 Months	Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day,	, Year)	9. Birthp Cour	place (State or Foreign
	Director		269-48-7444 58  Usual Residence of Decedent	113.					11/20/1	1950_		ОН
	land ow			Town or Lo	cation						1	0d. Inside City Limits
	Many i-f sh	ğ	MD Montgomery Silv	er Sp	ring							1∑Yes 2□No
	r 28a	Director	10e. Street and Number		10f. Zip C	ode			1	0g. Citizer	of What Cour	ntry?
	h with	<u>a</u>	1131 University Blvd. West		209	10				USA		
	deat	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	13. \			spanic Orig	gin? (Spec	cify Yes or No- Rican, etc.)		Race - Americ Black, White,	
9	after or It	/Fu	1 Never Married 2 Married 1 No		1 ☐ Yes 2		Specify:	, , , , , , , , , , , , , , , , , , , ,		So	ecify:	
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0 0	filed Hygie ther ant,	o O	17. Father's Name (First, Middle, Last)	LIICI	ерген		18. Mother	r's Name	(First, Middle, I			iustry
Maryland	ed ital	œ	Clarence Denson Jr.						Justice		ŕ	
2	s 1 and 2 should be if Health and Mental Item 27 is marked of other traumatic even	은	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ng Address (				Route Number	r, City or To	own, State, Zip	Code)
	and 2 saith ar n 27 is		Frances J. Denson/mother		,							MD 20910
Baltimore,	s 1 and 2 f Health Item 27 other tra				sition (Name						ion - City or To	
ê	00		I Build 2 Dictemation 3 Themoval norm state		ian Cr			5–28-	-2009	Alava	ndria,	VΔ
	permit. Page Department Importent: Il any injury o		21. Signature of Funeral Service Licensee						rshall'			
ñ	Per		Julia PM au hall	42	217 9t	h St	. NW	Wasl	hington	DC 2	0011	
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<u> </u>	w require been sig should b	q pa	Hypertension						1 🗆 Y	es 2 🛣 N	√o 3 🗆 Prot	oably 4 □Unknown
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	an: tifica tor, p	Φ	25. Was case referred to medical				26. Place	of Death	(Check only on		1 🗆 163	253110
>	> S b	To B	examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☒ fnpatient 2 ☐ El	R/Outpatien	t 3 DOA	Dthe	-		ne 5 Reside		Other (Special	(y)
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DIVISION	r Att ter de lrect	ertification;	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At hom building, etc. (Specify)	e, farm, str	eet, factory,	office		2	81. Location (Si City or Town		lumber or Rura	al Route Number,
2	itel o	O										
	To the Hospitel or Attandi within 24 hours after death. To the Funerel Director: A completely filled in by the to	edical	29a. Certifier  (Check only  1  Certifying Physician: To the best of my knowl  2  Medical Examiner: On the basis of examination	edge, death n and/or inv	occurred at vestigation, in	the time	e, date and inion, deat	d place, a h occurre	nd due to the c d at the time, d	ause(s) an late and pla	d manner as s ace, and due t	tated. o the cause(s)
	the the mplet	Med	one) and manner stated.  29b. Signature and title of certifier		200	icense	number			Od Data c	igned (Month,	Day Year)
	F 3 F 8		235 Significant Control of the Contr									
L	r		" / ar fi age	X-		3579	}			5/24	/2009	
			30. Name and address of person who completed cause of death (Item 2		,	1	. C		WD 2001	0		
	Sta	te	Maria J. Tayag 1500 Forest (31. Date filed (Month, Day, Year)	re	-	⊥ve1	. spr	TiiR I	עשי בעאַן	U		
	Registr		MAY 28 2009 Pentin B.	par	Co.							
			ALVIET T	-								

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registra/MEND#120er		_		artment of rtificate of		nd Me		giene Reg. No.	2000		3792		
	Physici		1. Decedent's Name (First, Middle		14,120					2. Date of Dea Month May		2009		e of Death		
0	/Medio Examin		4a. Facility Name (If not institution 4308 Sir Walte	, give street and num	mber)		4b. City, Town,	or Location of 01ney	Death		4c. C	ounty of De				
Dag	Funeral Director		5. Social Security Number  416-66-4054  Usual Residence of Decedent	6. Sex 1 M 2 F	7. Age (In yrs.	last birthday) 57 Yrs.	If Under 1 Year Months Days		4 Hrs. 8 Min.	B. Date of Birt (Month, Da July 1	y, Year) 9, 19	9. B 051 M	rthplace (Sta Country) arylar	ate or Foreign ad		
DCS J	the Maryland 28a-f show notified at	rector	10a. State 10b. County  Maryland Montg  10e. Street and Number	omery		ity, Town or Lo	10f. Zip Code				10g. Citize	en of What C	¹ <del>X</del>	e City Limits Yes 2 □ No		
	3a or	at Di	4308 Sir Walter	Road			208	32			-	J. S.				
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Hodical Evarinar must be notified at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Marri 3 Widowed 4 Divorced	ed Armed For	2 Na 9/2-	-1785	Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 🕅 No		in? (Spec Puerto Ri	ify Yes or No- can, etc.)		1. Race - An Black, Wh Specify:	nerican India ite, etc. White			
Baltimore, Maryland 21215-0036	within 72 ho ene. than "natui	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1	-4or 5+)	(Give life.	dent's Usual Occi kind of work don DO NOT use retir	e during most of ed)	of working	'		of Busines	s/Industry	ent		
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/lan	uld be Menta arked	To B	David Denney					Lo	rrai	ne Dib	b1e					
, Mar)	and 2 sho saith and n 27 is me er traume		19a. Informant's Name/Relations Ava M. Denney -				ng Address (Stree Sir Wal						Zip Code) 20832			
imore	Pages 1 nent of Hi ant: If Iten ury or oth		20a. Method of Disposition  1 ★ Burial 2 □ Cremation  4 □ Donation 5 □ Other (Sp.		Ctata	cemetery, cre	osition (Name of matory or other pl Nationa	ace) 1 Cem 5/	Dat 28/2			•	r Town, Stat Virgi			
Balt	permit. Departi Importa any Inj once.		21. Signature of Funeral Service I	icensee Hottlem	yes#		a Name and Add dward Sa 091 Rock							20852		
	Physician /Medical Examiner	Jer	23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Arterio Sclerotic Cardiovascular Disease  a.  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):													
\$760,	icate be executed physician and s the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	or as a consec	quence of):										
.O. Box 6	ath certif	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)  23d. Date of deliver Month II										elivery Day	Year		
rds, P.	quires that the de an signed by the a uld be detached f		Part II. Other significant condition	ns contributing to de	eath but not res	sulting in the u	inderlying cause g	iven in Part I.			obacco us Yes 2□	37	to the cause Probably 4	of death?		
I Reco	sician: The law requir certificate has been si rector, page 2 should I	Completed by								24a. Was autop perfo 1 □ Yes	osv	death'	autopsy findi completion	ngs available of cause of		
Vita	sician: The certificate hirector, page	Be	25. Was case referred to medical examiner?	Linesitely.			lo			Check only o	ne)					
of o	ding Physi h. After this c funeral dire	2	1 Manner of Death		npatient 2	ER/Outpatie	nt 3 DOA	ther: 4 🗆 Nurs		e 5X Resid			ecify)			
Division of Vital Records,	fing Afte fune	Certification: To	1 Natural 5 Pending 2 Accident investig 3 Suicide 6 Could n 4 Homicide determi	ation	of Injury th, Day, Year) of Injury - At h	Injury	W	∃Yes 2⊟N	lo	If. Location (3	Street and		Rural Route	Number,		
ō	ospita hours ineral ly filled		29a. Certifier 1 🛣 Certifyin	g Physician: To the Examiner: On the ba	best of my kn	owledge, dea	th occurred at the	time, date and	d place, ar	nd due to the	cause(s)	and manner	as stated.	(c)		
	the Ho the 24 the Fu	Medical	one)		ner stated.	ation and/or ii			n occurred	at the time,						
	Vithin Comple	2	29b. Signature and title of certifier	18 Ha	rolly	S, ME	). D	35965				27, 2	nth, Day, Yes 2009	a <i>r)</i>		
_	(0		30. Name and address of person v	Harding 1	18111 P	rince		rive, S	Site	# 300,	, 01n	ey, Mo	1. 208	32		
	Sta Registr		31. Date filed (Month, Day, Year)		egistrar's Sign	atore And	del									

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State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Bianca 8:25 PM Bennel Demotte May 26 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's St. Thomas Nursing Home Hyattsville If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 27 F 215-84-9037 Director May 17, 1933 Srilanka Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f shov 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1XYes 2 No Director MD Prince George's Mt. Rainier 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20712 3262 Queenstown Drive #202 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status (unk) Black, White, etc. 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Asian 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) filed within Hygiene. 12 Homemaker Own Home alth and Mental Hv 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jet, Maryla
Jet, Maryla
Jermit. Pages 1 and 2 should be be partment of Health and Merimportant: If item 27 leany Injury or or any Injury or or Henry Theadore de Silva Flora Hart ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3262 Queenstown Dr. #202 Mt. Rainier, MD 20712 Lester Jerome Demotte/son Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State W. Arundel Crematory 05/29/09 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Colling Manues Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the deease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. et and Death Week Immediate Cause (Final **Physician** Due to (or a consequence of): disease or condition resulting in death) /Medical Examiner neumo Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine executed burial-trans and resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician for use as the buria The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) signed by the a d be detached for o 9 ☐ Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ۵ D146214 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been si ; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed this certificate latan Blogitus VILER 1 ☐ Yes 2 🗹 No 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl. one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi funeral ( 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Division 5 Pending investigation ours after death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 □Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital of within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) Etas Bung RI HyalTsuille Mis 20187 4723 K KMS 31. Date filed (Mont State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last, Day Year Month **Physician** aymon /Medical 4c. County of Death 4a. Facility Name of not institution, give street and number) 4b. City, Town, or Location of Death Examiner George any If Under 24 Hrs. T 8. Date of Birth (Month, Day, Oct 11 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. **7** 4 birthday **Funeral** , 1934 Months Days 1 1 M 2 □ F Hours 577-44-7938 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Marifical Extrainer must be notified at once. 1X Yes 2 No Temple Hills Md Prince George Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20746 3394 Curtis Drive #203 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 XXNo Specify. Specify þ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) National Park Servic Tree Surgeon 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) William Dudley Bulah Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8101 Daniel Drive Forestville, Md. 20747 Deborah Clemons (Daughter) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Mem Park Landover Maryland 05-28-09 4 Donation 5 Other (Specify) 20011 21. Signature of Femeral Service Lice 22. Name and Address of Facility Tyrone J. Young 719 Kennedy St.NW WashDC 23a. Part 1. Enter the disease, or shock or heart failure. List Approximate Interval Between Onset and Death ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediat Cause (Final Mocardi **Physician** disease or condition resulting in death) /Medical Due to ( Las a consequence of): Examiner PSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discass or highly that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed ute KE burial-tran Due to (or as a consequence of) resulting in death) Last Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month 5 Other (specify) signed by the a Ö ☐Yes 2☐No 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, \$ 3 Probably 4 Unknown 1 □ Yes 2 □ No Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was ar has page 2 s autopsy performe certificate 1 ☐ Yes 2 ☑ No of Vital | 2 5 1 ☐ Yes Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ W Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir this 27. Mann Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1 ☐ Yes 2 No 2 Accident 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and titl

CR 10

State Registrar Hitesh

31. Date filed (Month, Day, Year) 32. Registrar's Signature

MAY 2 8 2009 Secure 5. Figure 5.

MD

Amin

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11701 Livingston

Rd.

Washington,

Examiner and burial-trar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) May 26, 2009 10:07 AMM Irma Jones Daniels 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Prince George's Ft. Washington Hospital Ft. Washington 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Country) Louisiana 1 ☐ M 2 🖫 F 10, 437-22-1991 85 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 XXIo Prince George's Ft. Washington Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a or 20744 USA 10410 Parapet Court Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or **Black** 1 ☐ Yes 2√√ No Specify. ğ 3 KWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Licensed Practical Nurse Medical permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygic Important: If item 27 is marked other i any injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Prudhame **Fdward** Jones Rose Mary ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10410 Parapet Court Ft. Washington, Maryland Inna Moss / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 XX remation 3 ☐Removal from State May 31,2009 Kalas Crematory Edgewater, Maryland 4 ☐ Donation 5 Other (Specify) 21. Signature of preral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 1. chis 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE **Physician** /Medical Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for ( in the past 12 months? 1 ☐ Yes 2 🔀 No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Severe Aortic Stenosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed Coronary Artery Disease 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Congestive Heart Failure 1 Yes 2 No the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ▼ Yes 2 No Hospital: 2 1 Inpatient 2 KER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1xx Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 Homicide 1 Rertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of gertifig D53782 May 26, 2009 rson who completed cause of death (Item 23a) (Type, Print) Suresh Verghese MD 11701 Livingston Road #101 Ft. Washington, Maryland 20744 31. Date filed (Month, Day, Year) State MAY 2 8 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

UNK Baby Girl State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ BABY GIRL JANE DOE 1514 hrs Medical Examiner March 22, 2009 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's 8200 55th Avenue College Park 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign Country) UNK Months Hours Min Director Days UNK WK M 2XF UNK Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show 1 Yes 2 No UNK UNK UNK hours after death with the Maryland Director s 23a or 28a-f e notified at o 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? WK UNK UNK Funeral 11, Marital Status 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married Armed Forces' 2 Married Yes If Yes, Give Year Yes 2 No specify: UNK Specify: UNK Divorced þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages I and 2 should be filed within 72 fother than " Baltimore, MD 21215-0036 N/A N/A NA N/A Department of Health and Mental Hygiene.
Important: If item 27 is marked other it
injury or other traumatic event, the Med 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UNK ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAIMER PARK, MO. PG. COUNTY Homacide 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Clinton, Md. 5-22-09 Resurrection Cem Donation 5 Other Specify 22. Name and Address of Facility 6433 Old Alexandria Ferry Kd. 21. Signature of Funeral Saviola LEE F.H. MARYLAND CHINTON. mo0257 Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Multiple Injuries Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed Physician/Medical UNPENDED **AMENDED** attending physician or use as the burial Box 68760. 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown signed by the a g Unknown 23e. Did tobacco use contribute to the cause of death? Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. þ Yes 2 V No 3 Probably 4 Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? death' Yes 2 1 V Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director; 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Hospital: 1 examiner? Other 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene ۵ 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject assaulted FOUND: Natural Yes 2 V No Pending Mar 22, 2009 1500 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide or Town, State) 8200 55th Avenue, College Park, MD determined 4 V Homicide (Specify) Lake Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 23, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 2009 egistrar's Signature State Registrar

DHMH 17 Rev 1/2001

OCME

ORIGINAL

			For State Registr <i>a</i> r	State of Mai	•	epartment of F Certificate of			Reg. No.2	18797
Phy	ysicia	ın	1. Decedent's Name (First, Middle, Florence Eliza		derfer	-		2. Date of Dea Month May	21, 200	3. Time of Death 7:50 a M
*34	ledic amin		4a. Facility Name (If not institution,			4b. City, Town, o	r Location of Death		4c. County of De	
1			539 East Drive	17.4	// 1A E! No		erna Park	O Date of Birth	1	rundel
Fund Direct			215-30-6409	. Sex 7. Age 1 ☐ M 2 🖾 F	(In yrs. last birtho	Months Days	Hours Min.	8. Date of Birth (Month, Day Aug • 17	1911 Pe	irthplace (State or Foreign Country) ennsylvania
/land	18		Usual Residence of Decedent  10a. State 10b. County	1	IOc. City, Town o	r Location				10d. Inside City Limits
e Mary	THE O	Director		Arundel	Seve	rna Park				1 □Yes 2 No
h with th	atbers	al Dire	10e. Street and Number 539 East Drive			10f. Zip Code	21146		10g. Citizen of What (	
ire, INIALYICATIO ZIZIS-UUSO s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show	Exacting	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☎ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:	er in U.S.	13. Was Decedent of H If Yes, specify Cub 1 □Yes 2 🕱 No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wh Specify: W	
13-6 n 72 hc "natu	Rdica	letec	15. Decedent's (Specify only highest	Education grade completed)	1 (6	ecedent's Usual Occup Rive kind of work done fe. DO NOT use retire	during most of work	king	16b. Kind of Busines	s/Industry
C C I C I	The M	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Seamst			Cloth	ing
should be filed wanted Hygie marked other t	ic event,	To Be C	17. Father's Name (First, Middle, La Robert Thompson					e (First, Middle, Levina	Maiden Surname) Rummel	
2 shour and N is mar	ranmat		19a. Informant's Name/Relationship		ı	ailing Address (Street				
1 and 2 Health Hem 27	other t		Siretta Carol R  20a. Method of Disposition	11ey/Daugnte		582 North ( sposition (Name of crematory or other place			Edgewater 20c. Location - City of	
partimore, reperting the partment of Healt Important: If item 2	jury or		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		Meadowi	cidge Memor	cial 200	09	Elkridge	, MD
Dermit Depar	any in		21. Signature of Funeral Service Lie	sensee SAL		Barranco 8 495 Gov. F	Sons. P.	.A. Sev	erna Park erna Park	Funeral Home
Physic /Medi Exami	ical		23a. Part 1. Enter the disease, or conshock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	_a Conge	consequence of):	enter the mode of dyi	ng, such as cardiac	or respiratory ar		Approximate Interval Between Onset and Death
ficate be executed physician and		edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c athe	consequence of):	eposis				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	ched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	Sy .		23d. Date of o Month	delivery Day Year
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The law requirecate has been si	24a. Was an autopsy performed? 1   Yes 2   No 3   P									
sician certifi	rector	Be	25. Was case referred to medical examiner? 1 ☐ Yes 25 No	Hospital:	A [[ FD/0 /	ationt 3 DOA Oth	26. Place of Deat	1		
ig Phy Control of the	neral d	n: To	27. Manger of eath	28a. Date of Injury	2 ☐ ER/Outpa 28b. Tim Year) lnju	e of 28c. Inju	4 Li Nursing no		lence 6 ☐ Other (S low injury occurred	pecify)
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e Hospita 24 hours e Funeral	ereiy rille	edical C	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the best of aminer: On the basis of e	xamination and/o	eath occurred at the tiper investigation, in my	me, date and place opinion, death occur	, and due to the rred at the time,	cause(s) and manner date and place, and c	as stated. lue to the cause(s)
To th To th	фио	Me	29b. Signature and title of certifier	eMD		D 6	5e number 56447	21	29d. Date signed (Mo	onth, Day, Year)
och			30. Name and address of person wh Amanda Mulon	completed cause of dea	ith (item 23a) (Ty	Highwa	y Amd	d mp	21012	
Par	Stat gistra	_	31! Date filed (Month, Day, Year) MAY 27	2009 32. Redistrar	s Signature	Highwa				

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		Pleas	<b>se Type or Pri</b> State of M		d / Dep	artment of H	lealth and l			ible.					
Physici		1 - State Registrar  1. Decedent's Name (First, Middle Robert Alva Dix			Ce	rtificate of	Death	2. Date of Death Month May 23,	Day	) 0 9 Year	3. Time of Death 3				
/Medio Examin		4a. Facility Name (If not institution  Anne Arundel Me				4b. City, Town, o	r Location of Deatl		4c. County						
Funeral Director		5. Social Security Number  5.79-03-5858			last birthday Yrs.			8. Date of Birth (Month, Day, 3/20/19	Year)	9. Birthp	Birthplace (State or Foreign Country) Shington, D.C.				
D	ī	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince	Coomacia	10c. City	y,TownorL Sowie	ocation				1	0d. Inside City Limits				
with the Ma a or 28a-f	Funeral Director	10e. Street and Number P.O. Box 693	e George s		OWIE	10f. Zip Code 20720		10	og. Citizen of	What Cour					
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 23a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status  1 ☐ Never Married 2 ☐ Marr 3 ☒ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces ied 1 □ Yes 2 ☑ If Yes, Give Year or Dates	? No	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)						14. Race - American Indian, Black, White, etc. Specify: White				
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t be filed w ntal Hygier ed other ti event, th	Be	17. Father's Name ( <i>First, Middle, Last</i> )													
id 2 should Ith and Me 27 Is mark traumatio	To	19a. Informant's Name/Relations Edward Dixon	n, State, Zip												
Pages 1 an lent of Heal nt: If Item 2 ry or other	Edward Dixon  20a. Method of Disposition  1 SD unial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Fort Lincoln  5050 Church Road, Bowie, Maryland 20720  20c. Location - City or cemetery, crematory or other place)  Fort Lincoln  May 28,2009 Brentwood														
permit. Departm Importal any inju		21. Signature of Euneral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road, Bowie, Maryland 20715													
Physician /Medical Examiner	L	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):													
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nding use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1													
w requires that the death been signed by the atte should be detached for	þ	SELL SCHOOL COLOR COLOR COLOR STAND STAND STAND													
The law recate has bee page 2 sho	Completed							24a. Was a autops perforr 1  Yes	y	o. Were aut prior to co death? 1 □ Yes	opsy findings available ompletion of cause of 2 ☐ No				
To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  Matural 5 Pendir	Hospital: Inpa		ER/Outpation 28b. Time Injury	of 28c. Inju	her: 4 Nursing lary at ork?	eath (Check only on Home 5 Reside 28d. Describe ho	ence 6 □O		ify)				
i or Attendi after death. Director: A d in by the fi	Certification:	2 Accident investi 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of i	njury - At ho etc. <i>(Specif</i>	ome, farm, s	M 1 catery, office	]Yes 2□No	28f. Location (St City or Town	reet and Nur n, State)	nber or Rui	ral Route Number,				
he Hospita in 24 hours he Funeral pletely fillec	edical	(Check only 2 Medical one)	ng Physician: To the be Examiner: On the basis and manner	of examina	owledge, dea ation and/or	investigation, in my	opinion, death occ	curred at the time, d	late and place	e, and due	to the cause(s)				
To Take The	Š	29b. Signature and title of certifie				D2.	70 28	2	9d. Date sign	ned (Month	n, Day, Year)				
OB.	ata-	30. Name and address of person  Cl r G S  31. Date filed (Nonth, Day, Year)	iora	death (Iten	110	Print) A	ue,	Ste 231	1, A	nap	lolg MD 21				
Regist	ate rar		2009 Sensu	~ /	1. 1	all	-			/					

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		1	For State of Maryland / Dep  State of Maryland / Dep  Registrar  Ce	artment of Health and h rtificate of Death	Reg.	0000 10700
	Physicis		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month May 25	Day 2009 13:46 M
mety.	Physicia /Medic	al	Raymond Ellsworth DeVaughn 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		2009   13:46 M   4c. County of Death
	Examin	er	Anne Arundel Medical Center	Annapolis		Anne Arundel
	Funeral Director		5. Social Security Number 6. Sex 1 AM 2 F 88 Yrs.	If Under 1 Year   If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye) 02/08/192	ar) 9. Birthplace (State or Foreign Couptry) Mary Land
	n and	-	Usual Residence of Decedent           10a, State         10b, County         10c, City, Town or L	ocation		10d. Inside City Limits
	Maryla f sho	tor	Maryland Anne Arundel Edge	water		1 □Yes 2 ☑No
	with the		10e. Street and Number 24 Leeland Road	10f. Zip Code 21037		Citizen of What Country? Inited States
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Inc. and Call Francian Call Call Call Call Call Call Call Ca	by Funer		Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 XNo Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
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and	be file	m	17. Father's Name (First, Middle, Last) William Henry DeVaughn	ļ	e Boteler	den damame)
Maryl	d 2 should th and Me 7 is mark traumatic	၉ .	19a Informant's Name/Relationship (Type Print) 19b. Mai	ing Address (Street and Number or Ru	ıral Route Number, C	ity or Town, State, Zip Code) 7 land 21037
Baltimore, Maryland 21215-0036	Pages 1 and lent of Heal nt: If item 2 ry or other		20a. Method of Disposition 20b. Place of Disposition	osition (Name of matory or other place) National Cemetery 05/		c. Location - City or Town, State
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	ificate be executed  By physician and physician and streep interest its physician and streep interest its physician and physicia	edical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	L Bleeding		Onset and Death
O. Box 68	death certi e attending d for use a	Physician/Medi		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
σ.	w requires that the d been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to the cause of death? 2 □ No 3 □ Probably 4 ☒ Unknown
of Vital Records,	e la has le 2	Completed by			24a. Was an autopsy performe 1 ∐Yes 2 [	24b. Were autopsy findings available prior to completion of cause of death?  ↑No 1 □ Yes 2 □ No
/ita	Physician: The ribis certificate ral director, pag	Be	25. Was case referred to medical examiner? Y	0.0	ath (Check only one)	
on of \	ng Phys After this Ineral dir	ion: To	1 ☐ Yes 2 ☐ No ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat  27. Manner of Death 1 ☐ Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident investigation	of 28c. Injury at	Home 5 ☐ Residence 28d. Describe how	ce 6 ☐Other (Specify) injury occurred
Division	or Attending after death. Director: After I in by the funer	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined building, etc. (Specify)		28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical Co	29a. Certifier (Check only one)  1  Certifying Physician: To the best of my knowledge, de control one)  1  Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and plac investigation, in my opinion, death occ	ce, and due to the cau curred at the time, date	use(s) and manner as stated. e and place, and due to the cause(s)
	To the within To the compl	Me	29b. Signature and little of certifier	29c. License number	290	d. Date signed (Month, Day, Year)
	RA	0	· Cleckler/	D16410	M	ay 26, 2009
_	illi)	*	30. Name and address of person who completed cause of death (Item 23a) (Typ Gabriel B. Jaffe, 7500 Hanover Parkway, Suite	e, Print) 105, Greenbelt, Maryl	and 20770	
	Sta Regist		31. Date filed (Month, Day, Year)  32. Registrar's Signature	bake		

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 23 Yes 053 LIBERT 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Severna Park 211 Pine Avenue If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Ye July 18, 5. Social Security Number 7. Age (In yrs. last birthday Days Hours Year Months 1 M 2 □ F 140-16-5372 New Jersey 87 Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location 1 ☐ Yes 2 No Anne Arundel Severna Park 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21146 USA 211 Pine Avenue 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married White 1 ☐ Yes 2X No Specify. Specify: WW II 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) David Taylor College (1-4or 5+) 5+ Elementary/Secondary (0-12) Mechanical Engineer Research Lab 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Amelia Gerace Giuseppe Di Liberti 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Margaret Di Liberti/Wife 211 Pine Avenue Severna Park, MD 21146 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition May 28, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2009 Crownsville, MD 22. Name and Address of Facility Significant Service Ligense Barranco & Sons, P.A. 495 Gov. Ritchie Hwy. Severna Park Funeral H Severna Park, MD 21146 MATE P 11. Enter the disease, or committations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, oc , or heart failure. List only one cause on each line. Immediate Cause (Final LUKOMIA disease or condition resulting in eath) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Joseph an injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 ☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 2 No 2 □No 1 □ Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify)

/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician

**Physician** 

Examiner

10a. State

MD

**Funeral** 

Director

28a-f show

or items 23a or

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Exercipes once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Examiner must be notified at

Director

Funeral

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Completed

Be

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death with the Maryland

/Medical

Exami Physician/Medical ģ Completed Be Certification: To

IF FEMALE 9 Unknown

23b. Was decedent pregnant in the past 12 months?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 1 Tes 2 No

Name and address of person

MAY 27

27. Manner of Death

Natural

2 Accident

3 Suicide

4 ☐ Homicide

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 5 Pending investigation

28b. Time of Injury 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

6 ☐ Could not be

29c. License number

29d. Date signed (Month, Day, Year) PEYENSE HIGHWAY ANNAPOLUMO 2140,

31. Date filed (Month, Day, Year) State

Mim NI 32. Registrar's Signature

ho completed ause of death (Item 23a) (Type, Prin

YUI

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

n 24 hours aft e Funeral Di etely filled in

within 2

npletely

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 23, 2009 Robert E. Elwell, Sr. 8:35a M May /Medical 4c. County of Death
Anne Arundel 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Annapolis Somerford Assisted Living 9. Birthplace (State or Foreign Country)
Maine 8. Date of Birth (Month, Day, Aug. 3, Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** 004-28-1883 Months Days Hours Min. 1**X**) M 2□ F 79 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show event, the Medical Examiner must be notified at Anne Arundel Annapolis MD 1 TYes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 2 and 1 injury or other traumatic event, the Wedical Evaninar mental events.

Once. USA 21409 1256 Seabright Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ™ Syes 2 □ No 1950 If Yes, Give Year or Dates: 1950 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1950-1959 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nationwide Insurance Underwriter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pearl Clockedile John Elwell ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1256 Seabright Drive Annapolis, MD 21409 Ann Marie Elwell/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
HOLY Trinity Russian Date 20c. Location - City or Town, State 20a. Method of Disposition May 25, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) Orthodox Cemetery 2009 22. Name and Address of Facility Barranco & Sons, P.A. 21. Signature of Funeral Service Licensee Severna Park Funeral Home MD 21146 Severna Park, 495 Gov. Ritchie Hwy. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset end Death Immediate Cause (Final disease or condition resulting in death) **Physician** uears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ξ. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Mknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performe 2 No 1 ☐ Yes 2 25, Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical one and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

ans Hwy Millersviller

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2009 1:45 May Ам Bayard Ellifritz /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Anne Arundel Regency Park Assisted Living Gambrills 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
March 28, 1915 West Virginia If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 1 1 2 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days Director 214-07-4698 94 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f shevent, The Medical Examiner must be notified 1 Ves 2 No Director Maryland | Prince George's Bowie with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20715 USA 2717 Kenhill Drive by Funeral death Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black. White, etc. filed within 72 hours after 1 ∐Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No 3X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, I'm Ma once. Elementary/Secondary (0-12) College (1-4or 5+) Railroad 12 Amtrak 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Pearl Metcalfe ပ Floyd Ellifritz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2717 Kenhill Drive Bowie, MD 20715 Ronald Ellifritz/ Son 20b. Place of Disposition (Name of cametery, crematory or other place)
Trinity Lpiscopa1 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 5/30/2009 Upper Marlboro, MD Church Cemetery 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Fungfal Service 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that cause, the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 641 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year ed by the a detached for 5 Other (specify) 1 Tyes 2 TNo 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 bett 1 ☐ Yes 2 ☐ № 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has page 2 autopsy performed? 1 □ Yes 2 E 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ☐ N After this funeral din Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 [LHatural 5 ☐ Pending investigation I Director: A death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide hours after 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

To the Hospital Within 24 hours a Within 24 hours a To the Funeral It completely filled completely filled hospital and a management of the following the filled control of the following the filled control of the following the filled control of 
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31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

ORIGINAL

eath (Item 23a) (Type, Print

Magi

Registrar's Signature

of person who completed cause of

Year)

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 10b, per Fh g892 6/25/09 TT

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009 Year Day Month 10:44 A M **Physician** 4, June THOMAS FENDER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL 8. Date of Birth
June 17, 1940

8. Birthplace (State of Foreign)
Coventry)
Carolina If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1**№** M 2□ F 68 Director 240-56-8816 Usual Residence of Decedent 10b. County Washington 10d. Inside City Limits show 10a. State 10c. City. Town or Location the Mudical Exprimer must be notified at XXYes 2 □ No Director 28a-f MD **Frederick** Knoxville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō or items 23a 19024 Miller Ave. 21758 U.S.A. Funeral filed within 72 hours after death Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Auto Manufacturer Painter 8 and Mental Hygi 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 Is marked any Injury or other traumatic ev William Fender Zula Taylor 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diana L. Fender 5539 Parkview Ct. Frederick, MD 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Burial 2 ☐ Cremation 3 ☐ Removal from State 6/9/09 Bel Air Mem. Gdns Bel Air, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Tarring—Cargo Funeral Home, P.A. 21. Signature of Funeral Service Licensee Aberdeen, Maryland 21001-3399 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myscardial minute **Physician** Acute disease or condition resulting in death) /Medical Due to (or as a consequence of): COVURAN Discan Veavs Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ed by the a detached fi O 9 Unknown σ. s been signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Ñ certificate has autopsy page 1 ☐Yes 2 ☐No of Vital Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2₺No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 1 Natural 5 Pending investigation ours after death.

neral Director: A
filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide e Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brunswick MD 21716 Kinland MD 610 31. Date filed (Month, Day, Year) 32. Registrar's Signatu

DHMH 17 Rev 1/2001

State

Registrar

JUN 1 1 2009

09-04366	Please Type or Print in Black Indelible Ink. Ensure All Copie	gione
Michael Anthony Fan	State of Maryland / Department of Health and Mental Hy	
R	For State Certificate of Death	Reg. No. 2. Date of Death 3. Time of Death
Physician/	. Decedent's Name (First, Middle, Last)	Month Day Year 1130 hrs
Medical Examiner	Michael Anthony tanning  4b. City, Town, or Location of Death	4c. County of Death
•	a. Facility Name (if not institution, give street and manager)	Prince George's
	10322 buswell Flace	8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min.	Country)
Director	085-64-1399 1 XM 2 F 31 Yrs. Yrs.	111-7-1971 BRONX, NY
	Usual Residence of Decedent	10d. Inside City Limits
ā	10a. State 10b. County 10c. City, Town or Location	1 Yes 2 No
nd Show	MC Mecklenburg Charlotte	10g. Citizen of What Country?
Maryland 28a-f show d at once.	10e. Street and Number	USA
death with the Maryland or items 23a or 28a-f sho must be notified at once.	15008 Easywater Lane 28218	
with with 1 s 233	11. Marital Status  12. Was Decedent Ever in U.S.  Armed Forces?  13. Was Decedent of Hispanic Origin? ( S  If Yes, specify Cuban, Mexican, Puerto	
or items 23 must be no	1 Never Married 2 Armed Forces? If Yes, specify Cuban, Mexican, Free It	K GOV
fier de	3 Wildowed 4 Divorced of Parks:	work done 16b. Kind of Business/Industry
nurs aft ntural" amine d by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use rel	
72 hc	Elementary/Secondary (0-12) College (1-4 or 5+)	PIT
5-0036 ed within 72 hour lygiene other than "natu he Medical Exar Completed	441 Selvice Ne.	e (First, Middle, Maiden Surname)
5-0036 lied within 7 Hygiene. I other than the Medic	17 Father's Name (First, Middle, Last)	agie, Jones
21) be fill mral F rrked ent,	THE FULL PULL NO	Rural Route Number, City or Town, State, Zip Code) 2 \$ 2 7 3
nore, MD 21215-0036  ages I and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene it: If item 27 is marked other than "matural", or items 23a or 28a-f shu other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	19a. Informants Name/Relationship (Type, Thirt)	
MD d 2 shoulth and ulth and an a 27 is	New Olives   Size of Dispersion (Name of cemetery	Date 20c. Location - City or Town, State
re, M 1 and 2 F Health Fritem 2	20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State	Japlan Paplan 11 Papl
Baltimore, pernit Pages I ar Department of Hei Important: If ite	Heritige Cembery V	- Collocation - 1 os
Baltimo pernit Page Department o Important: injury or ott	21. Signature of Funeral Service Licensee	PRIDGEN Funeral sorvice
	Juliulia Phalen 19908 SUS Sufra	or respiratory arrest shock or heart Approximate Interval
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.	Between Onset and Death
Medical	Immediate Cause (Final disease a.Aortic dissection	
aminer	or condition resulting in death)  Due to (or as a consequence of):	
	Sequentially list conditions, b	
ner	If any, leading to immediate Due to (or as a consequence of):	
ted Insit Examine	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	
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executed an and al - trans	X UNPENDED	
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Box 68760, e death certificate be the attending physic ed for use as the bur hvs.ician/Mec	23b. Was decedent pregnant in the a Live birth 2 Fetal death 3 Ectopic pred	gnancy Month Day Year
th cer tendi	4 Pregnant at time of death 5 Other (Specify)	
Bo e dear the arther ar		23e. Did tobacco use contribute to the cause of death?
P.O. es that the igned by be detach	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1 Yes 2 No 3 Probably 4 Vunknown
tal Records, P.O. Box 68760, cian: The law requires that the death certificate be executed certificate has been signed by the attending physician and ector, page 2 should be detached for use as the burial - transit Ref. Commissed by Physician/Medical Exerces.	Hypertensive cardiovascular disease	24a. Was an 24b. Were autopsy findings available
Records, I The law requires ficate has been significate has been significant beautified.		autopsy prior to completion of cause of death?
e law e has ge 2 s		1 ✔ Yes 2 No 1 ✔ Yes 2 No
Division of Vital Records, real or Attending Physician: The law requints after death.  The Insert death of the this certificate has been seled in by the funeral director, page 2 should the contribution. To Be Committee		
/ital F ysician: his certifi director,	examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other4 No.	ursing Home 5 Residence 6 Other: Scene
f Vir Physic er this	27 Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred
n of Noting Ph. h After t	1 X Natural 5 Pending (Month, Day, Year)	
Sio Atter deat cector by th	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Division or real or Attending trial or Attending trial or Attending trial Direction: After liled in by the fune or attending trial or attending tr	3 Suicide 6 Could not be determined (Specify)	of Town, State)
spita hours	Let the time date and place	and due to the cause(s) and manner as stated.
Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buring and Contributed Contributed by Physician/Med	Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur	od dit tile time; and a
To the within To the comp	and manner stated.  29b. Signature and title of certifier  29c. License number	29d. Date signed (Month, Day, Year)
	O.C.M.E.	June 2, 2009
	11/1/0	
CR	30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore	e, MD 21201
	Nussell Alexander (ME)	
Sta Registr		

DHMH 17 Rev 1/2001 OCME 2006

P.O. Box 68760. Division of Vital Records,

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physicien: thours after death unerel Director: / within 24 hours a To the Funerel D

State Registrar

Medical

29a. Certifier

completed cause of death (Item 23a) (Type, Print) Name and address of persol 31. Date filed (Month, Day, Year, MAY 2 9 2009

29b. Signature and fittle of certifie

32. Registrar's Signatu

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Comparison of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

21438

29d. Date signed (Month, Day, Year)

6 HWAY ANNAPOURS MD21401

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month 06 Day 6:35 AM lames 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death CHARLES 8374 GILROY ROAD NANJEMOY 8. Date of Birth (Month, Day, Year) 12-20-1928 9. Birthplace (State or Foreign WASH , D . C . If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Days 1 J⋅M 2 🗆 F 80 215-26-0671 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location CHARLES NANJEMOY 1 ☐ Yes 2 ☐ Xio MD. 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number U.S.A. 8374 GILROY ROAD 20662 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 11 Marital Status 1 ☐ Yes 2 ☐**X**No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify:WHITE 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 7th College (1-4or 5+) SAWMILL OPERATOR SELF EMPLOYED 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JAMES BARRY GILROY JOSEPHINE GILROY 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NANJEMOY, MD. 20662 JOICE GILROY-SPOUSE 8374 GILROY ROAD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition N☐ Burial 2 ☐ Cremation 3 ☐Removal from State GILROY FAMILY CEM. 6-6-09 NANJEMOY, MD. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility RAYMONDAFUNERAL SERVICE, P.A. LA PLATA, MD. 20645 M00479 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Obstructure Pulmones disease or condition resulting in death) Due to (or as a consequence of): 10 bacco Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 Yes

Physician /Medical Examiner Examine

Physician

/Medical

Examiner

10a. State

Director

Funeral

à

Completed

Be

**Funeral** 

Director

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

3altimore, Maryland 21215-0036

Physician/Medical

þ

Completed

Be

P

Certification:

Medical

sician and bunal-trans ed by the attending physician detached for use as the buna has been this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Division or Vital Records, P.O. Box 68760名

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Tilnknown

> 24a. Was an autopsy performe Yes 2

Nanjernoy ML

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

26. Place of Death (Check only one

25. Was case referred to medica examiner?
27. Manner of Death

5 Pending investigation

28a. Date of Injury (Month, Day Year) 6 Could not be determined

1 Inpatient

2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 A Natural

2 Accident

3 ☐ Suicide 4 ☐ Homicide

> 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

poerson 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RNP Port Tobacco Rd Apperson 32. Registra/'s Signature Day

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 2009 Patricia Ann Gerleve 4a. Facility Name (If not institution, give street and number)
Seasons Hospice Unit
Northwest Hospital 4b. City, Town, or Location of Death 4c. County of Death Baltimore Randallstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, April 3, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number <sup>Year)</sup> 1957 Months 1 □ M XX F Mary 1 and 52 213-70-4961 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes XX No Baltimore Baltimore Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21221 11 East Orville Road by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 X No If Yes, Give Year or Dates: Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12)
Twelve Years College (1-4or 5+) Personal Residence Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary C. Mentlik William H. Trentler, Sr. ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O. Box 202, Conowingo, Maryland James J. Gerleve, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place)
West Nottingham
Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 05/24/09 Colora, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Lee A. Patterson & Son Funeral Home, P.A.
Maryland 21903-0767 21. Signature of Funeral Service Licenses M INMINIA

**Physician** /Medical Examiner

**Physician** 

Examiner

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventher must be notified at once.

/Medical

physician and stranger the burial-tranger attending pl detached sign be After this certificate has funeral director, page 2 s within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Hospital or Attending Physician: The law requires that the death certificate be execute

Division of Vital Records, P.O. Box 68760,

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	23a. Part 1. Enter the disease, or comp	lications that caused the death. Do not one cause on each line.	enter the mode o	f dying, such as cardiac	or respiratory arrest,	Approxin Interval I Onset ar	Between
	Immediate Cause (Final disease or condition resulting in death)	a. Metastahe Sa				Offset at	
Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b					
ysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 ☒No 9 □ Unknown		3 ☐ Ectopic preg 5 ☐ Other (speci			23d. Date of delivery Month Day	Year
d by Pr	Part II. Other significant conditions co	ontributing to death but not resulting in the	e underlying caus	e given in Part I.		o use contribute to the cause	
complete					24a. Was an autopsy performed;	24b. Were autopsy findin prior to completion death?	gs available of cause of
Be	25. Was case referred to medical				th (Check only one)		
	examiner? 1  Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	tient 3 DOA	Other: 4  Nursing He	ome 5 Residence	6 Dother (Specify)	SPICE
ation:	27. Manner of Death 1			Injury at Work? 1 □ Yes 2 □ No	28d. Describe how in	jury occurred	
Medical Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, o	ffice	28f. Location (Street City or Town, St	and Number or Rural Route Nate)	lumber,
dical C	29a. Certifier 1 Certifying Physics (Check only one)	vsician: To the best of my knowledge, diner: On the basis of examination and/o	eath occurred at or investigation, in	the time, date and place my opinion, death occu	e, and due to the cause rred at the time, date	e(s) and manner as stated. and place, and due to the caus	se(s)
Me	29b. Signature and title of certifier	1 R 1-	29c. L	icense number		Date signed (Month, Day, Yea	r)
	> Leva Ochal	2 Dewen	H	45931	//	1ay 20 44 700°	7

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

2835

3

Smith Avonue Such 203 Baltmore MD

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

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		1 - For State Registrer	State of Marylar	·	ent of Health and ate of Death		еде 0 0 9	18808
E A	<i>†</i>	1. Decedent's Name (First, Middle, Las	t)	2.1		2. Date of Deat Month	h Day Year	3. Time of Death
Physic /Med		Ben Jami	n Lee	Gibs	ON	5	21 200	96:45 PM
Exam	iner	4a. Facility Name (If not institution, give	1./ 1	4b. C	ty, Town, or Location of Dea	th	4c. County of Dea	ath I i
The state of the s	The state of	5. Social Security Number 6. Se		S (	GMby d9		Dorci	hes'ter inthplace (State or Foreign
Funera Directo			ØM 2□ F	Yrs. Month			Year) (	Naryland
Ď		Usual Residence of Decedent				march	adilas v	navgrand
arylar ehow	_	10a. State 10b. County		ity, Town or Location	F 1			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
U36  Ours after death with the Maryland  oil; or fieme 28a or 28a-f show  Erant ner count by chilling at	Director	10e. Street and Number	ester	Cambr			0	
with	ā	111. 0	$C \perp \dots \perp$	101.	Zip Code	"	og. Citizen of What C	
Jeath The 23	Funeral	410 Pine	12. Was Decedent Ever in U	J.S. 13. Was De	cedent of Hispanic Origin? (	Specify Yes or No-	14. Race - Am	
<u> </u>		1 Never Married 2 Married	Armed Forces?		cedent of Hispanic Origin? (Specify Cuban, Mexican, Puer	to Rican, etc.)	Black, Wh	nite, etc.
15-0036 72 hours after "naturel", or ite	dby	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 LJ Yes	2 No Specify:		Specify: B	lack
2 2 2	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Decedent's U (Give kind of	work done during most of wo	nking	16b. Kind of Busines	s/Industry
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lar Jar Jar Jar Jar Jar Jar Jar Jar Jar J	To B	BENJamin	Lee 6ib	SON, SK	Sopi	rie B	lackwe	e 11
Mary d 2 shouth and h 7 is mai		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailing Addre	ess (Street and Number or R			
- 650 -		Ethel Mae	GIBSON	410 P	we Street C		e, MD.	21613
Saltimore, Dermit. Pages 1 a Department of Her Mportant: If item Prof. injury or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		Place of Disposition (fi cemetery, crematory of	r other place)	, [	2 Location - City o	or Town, State
Itim it. Pa dmen dmen rtant: njury	10	4 Donation 5 Other (Specify	1/0	augh Cen	Committee and the second secon	29/09 (	ambridg	e, MD.
Depa Dema	1 2	21. Signature of Funeral Service Licen:	2/2	Hew R	and Address of Facility 4 Funeral Washingto	Home, P. A	+, , , "	MD 2 1/ 13
K <sup>T</sup>		23a. Party. Enter the disease, or comp	plications that caused the dea	th. Do not enter the m	washing to	c or respiratory arre	Moriage,	Approximate
Dhysisian		23a. Partir. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	(	, , ,			70.1	Onset and Death
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Examiner	4	Constitution	h					
ם ב	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):				
<b>6U,</b> be executed ciclen and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consec					
fou, e be executed sicien and burial-transit	calE		Due to (di as a consec	querice or).				
			d					
BOX 08 ath certificat attending phy for use as th	Z/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn.				23d. Date of de	elivery
death death de atten	cla	in the past 12 months?	1 Live birth 2 Feta				Month	Day Year
Kordwires that the de been signed by the should be detached	Physician/Med	9 Unknown	9□ Unknown					
ires th	þ	Part II. Other significant conditions con hypertension		sulting in the underlyin	g cause given in Part I.			to the cause of death?
HECOTOS he law requires has been sign ge 2 should be	ompleted	ng per cer 10101					1	Probably 4 Dunknown
The law ate has boage 2 st	ID III					24a. Was a autops perform	y prior to	autopsy findings available completion of cause of
Page -	င်	25. Was case referred to medical				1 ☐ Yes 2	No 1 Ye	os 2□No
r Vita ysician: ysician: is certific director,	0 8	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3		ath Check only on	e) ence 6 ∏Other (Sp	nacihi)
VISION OF VICE Attending Physician: of death. ector: After this certific by the funeral director.	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury at Work?	28d. Describe ho		вспу)
Vitendin death. ctor: Aff y the fur	atio	1 Natural 5 Pending investigation		Injury M	1 Yes 2 No			
JIVISION  Tor Attending after death. Director: After in by the fune	ertification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Special	iome, farm, street, fact	ory, office	28f. Location (St. City or Town	reet and Number or F n, State)	Rural Route Number,
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To the Hospitel or Attending Phymbin 24 hours after death. To the Funerel Director: After the completely filled in by the funeral	Medical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	/sician: To the best of my knoiner: On the basis of examina and manner stated.	ation and/or investigati	and in the contract of a side of a con-	and a second sec		- 4- 44 (-)
ro the vithin ro the complex	₩ W	29b. Signature and title of certifier			29c. License number	25	9d. Date signed (Mor	nth, Day, Year)
1/		Moranco	n NO		HDD599	73	5/27/00	3
4		30. Name and a ress of person who c	ompleted cause of death (Iter	m 23a) (Type, Print)	1,000//	1		
		Patricia	Johnson	100 Bro	29c. License number  HO0599  Rmble C	ambria	8 140	
St Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature				
	100		The parties	A MICE	A			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First Middle Last) 2 Date of Death 3. Time of Death **Physician** Year Alice 7:458 M M. Grant 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner SALISBUR Wicomico COASTAL Hospice LAKE At the 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral**  Date of Birth (Month, Day, Year) Min Months Days Hours 1 ☐ M 2 🛣 F 033-20-9593 79 Director 10/11/1929 Massachusetts Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r 28a-f shov Director 1 XYes 2 No Salisbury Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important; or items 23a or important; If item 27 Is marked other than "natural", or items 23a or any Injury or other traumatic event, Its Medical Examinat must be not any Injury or other traumatic event, Its Medical Examinat must be not any Injury or other traumatic event, Its Medical Examinat must be not any Injury or other traumatic event, Its Medical Examination 200 Civic Ave. Funeral 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 □X'es 2 □ No If Yes, Give Year or DatesAYTTY 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 ☐ Married incre, Maryland 21215-0036 1 ☐Yes 2 🛣 No Specify ģ Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Police officer public safety 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be James William Grant Mary Neary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 James Grant III/Nephew 14155 Reading Ferry Rd., Princess Anne, MD21853 Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Salisbury Crematory 5/26/09 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications the caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CARCINOWA LUNG disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner OBSTRUCTIVE PHLMONARY HROMC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and burial-Due to (or as a consequence of) Box 68760, physician death certificate be Physician/Medical as the the attending IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 23d. Date of delivery 3 Ectopic pregnancy for Month Year Pregnant at time of death 5 ☐ Other (specify) P.O. I detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Š pe 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No this certificate 2 No 1 Yes 1 ☐ Yes the Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICA 1∐Yes 2⊞No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P I Director: After this id in by the funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours af ie Funeral Di eletely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only the To the within To the 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year)

State Registrar 80 Box 1733 SAUSAWY WE 21804

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JUNE 4,2009 Year SHIRLEY HOFF HENDRICKS 4:15P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHARLES 11746 LUCKNOW LANE LA PLATA 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) 2-10-1929 Funeral 6. Sex 7. Age (In yrs. last birthday) Days Months 213-32-2528 1 M 2 K 80 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland r 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits CHARLES LA PLATA 1 ☐Yes 2 X No MD. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumetic event, it a Modical Examinar must be re 11746 LUCKNOW LANE 20646 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 þ Specify: WHITE 1 ☐ Yes 2 No 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 MILITARY WIFE OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be item 27 Is marked or GLADYS CUNNINGHAM LEWIS BLANEY HOFF 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) COL. MEREDITH E.HENDRICKS-\$POUSE 11746 LUCKNOW LN. LA PLATA, MD. 20646 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot once. 1 Burial 2 ACremation 3 Removal from State | cemetery, crematory or other place) | 4 Donation 5 Other (Specify) | METROPOLITAN CREMATORY 6-11-09 | ALEX., VA. M00479 21. Signature of Foneral Service Licensee P. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) **Physician** rce · /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed bunial-transit Exam and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a d be detached for P.O. 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Nanknown Completed 24a. Was an autopsy performed? 1 □ Yes 2 □ 100 24b. Were eutopsy findings available prior to completion of cause of death? has certificate 1 ☐Yes 2 ☐No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home Specify) 1 | Yes 2 | No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deat Funeral Director: filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

completely

within 2

(Check only one)

29b. Signature and title of certifier

State Registrar

703 0 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUN 11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** <sup>™</sup>06/01/2009<sup>Year</sup> 11:27 AM MARY EMMA HARLOWE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** TALBOT 3729 MARVEL DRIVE TRAPPE 9. Birthplace (State or Foreign NORTH CAROLINA 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 10/26/1932 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 💢 F 76 242-48-2728 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, I'm Medical Exercity at the modified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1XIYes 2 ☐ No Funeral Director MARYLAND TALBOT TRAPPE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3729 MARVEL DRIVE 21673 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 ∑ If Yes, Give Year or Dates: 1 Never Married\_2 Married 2 **X**No Baltimore, Maryland 21215-0036 1 □Yes 2 XNo Completed by 3 Widowed 4 Divorced Specify: WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ALVIN RHINEHEART LAUBSCHER MARGRATE RUTH SEAWELL ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MARY KATHERINE SADLER / DAUGHTER 3729 MARVEL DR.TRAPPE, MD 21673 permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other 20b. Place of Disposition (Name of SCIENCE CARE COLORADO 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State 6/3/2009 4 X Donation 5 ☐ Other (Specify) AURORA, CO and Address of Facility
AN-BROMWELL FUNERAL HOME,
IGH ST, CAMBRIDGE, MD 21613 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical iovascular Disease Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ■ No Month 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) ¥ Yes 2 □ No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural ours after death.

neral Director: Af
filled in by the fur 1 ☐ Yes 2 🗆 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 690, DENTON MD 21629 GV 11 D , POB 32. Registrar's Signature

State Registrar 31. Date filed (Month, Day, Year)

P.O.

		Pleas	e Type or Pri							,
		For State Registrar AMEND#8per:IN		-		artment of r <i>rtificate of</i>	Health and N <i>Death</i>		giene Reg. No.?	18812
Physicia		1. Decedent's Name (First, Middle, Mary Elizabe	Last)					2. Date of Dea Month May 26	ath Day Yea	3. Time of Death 8:59 a M
/Medic Examin		4a. Facility Name (If not institution,					or Location of Death	min a	4c. County of De	
Funeral		Apex Health of  5. Social Security Number 6	. Sex 7. Ag		last birthday)	If Under 1 Year			M_23_1923 9. B	ontgomery  Birthplace (State or Foreign Country)
Director		579-22-1018 Usual Residence of Decedent	1□M 2 <b>X</b> F	8	6 Yrs.	Months Days	Hours Min.	April 2	2, 1923 N	orth Carolina
nyland thow Lat		10a. State 10b. County		10c. Cit	y, Town or Lo					10d. Inside City Limits 1 □Yes 2 ♣ No
the Ma 28a-f s notified	Director	Maryland Mo  10e. Street and Number	ntgomery		Silv	rer Spring	9		10g. Citizen of What	
th with 23a or ist be r	al Di	2700 Barker S	treet				910		USA	,
er dea items	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 Yes 2	Ever in U.	.S. 13.	Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	. 14. Race - Ar Black, W	nerican Indian, hite, etc.
urs a ai",o Exam	۵ ک	3€ Widowed 4 Divorced	If Yes, Give Year or Dates:	NO		1□Yes 2□No	Specify:		Specify: B	lack
"natur	Completed	15. Decedent's (Specify only highest	Education grade completed)		16a. Dece	dent's Usual Occup	pation during most of work d)	king	16b. Kind of Busines	ss/Industry
d withingiene.	dmo	Elementary/Secondary (0-12)	College (1-4or	5+)			e Assista		Departme	nt of the Nav
be file ntal Hys od othe event,	Be	17. Father's Name (First, Middle, La Raymond Jones	ast)				18. Mother's Nam		Maiden Surname)	
should nd Mer marke imatic	ျှ	19a. Informant's Name/Relationship	(Type. Print)		19b. Maili	ing Address (Street			er, City or Town, State	a, Zip Code)
and 2 salth a		Lawrence Edward	Holland/Sc						ing, MD 2	0903
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Foce.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3		20b. F	Place of Disponentery, cre tropol	osition (Name of matory or other pla itan Cre	matory J	une 6,	20c. Location - City	
mit. Pa		4 ☐ Donation 5 ☐ Other (Special Service Li			- 12	2. Name and Addre	ess of Facility	2009		a, Virginia
Imp Per any		Irlent /	/hi			500 Unive	ersity Bl	vd., W.,		pring,MD 2090]
Dhuaisian		23a. Part1. Enter the disease, or conshock, or heart failure. List of Immediate Cause (Final	nly one cause on each li	ne.	1			or respiratory ar	rest,	Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. A(2)  Due to (or as			disea.	)e			Unknows
Examiner	-	Sequentially list conditions,	b. — Due to (or as	a conseq	uence of):					
executed in and ial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	с.		,					
or cia	al Ex	resulting in death) Last	Due to (or as	a conseq	uence of):					
	edica	(1)	d							
The law requires that the death certificate to has been signed by the attending physoage 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Feta	aldeath 3	□Ectopic pregnanc	:y		23d. Date of Month	delivery Day Year
at the dea by the ai	ıysici	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	t time of c	death 5	Other (specify)_			World	Day Tour
signed by	oy Ph	Part II. Other significant condition	s contributing to death b	out not res	ulting in the u	underlying cause gi	ven in Part I.			e to the cause of death?
w require been si should t	eted	Lementia Severe p	, Adult	fa	lune	to Chris	ve 1			Probably 4 Unknown
The law ate has be page 2 s	Completed by	_		t i	vascu	dar di	case,	24a. Was autor perfo	prior death	autopsy findings available to completion of cause of 1?
	Be C	25. Was case referred to medical examiner?					26. Place of Dea		2 <b>2</b> No	es 2□No
hys this	၉	1 ☐ Yes 2 ☐ No  27. Manne of Death	Hospital: 1 ☐ Inpati		ER/Outpatie	III 3 DOA			dence 6 Other (S	pecify)
Attending r death. ector: After by the fune	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Da	y Year)	Injury	Wo	rk? ]Yes 2∐No	200. 20001150 1	iow injury occurred	
or Attendate after death Director:	Certification:	3 Suicide 6 Could no 4 Homicide determin		jury - At ho tc. <i>(Sp</i> ec <i>it</i>	ome, farm, st	reet, factory, office		28f. Location (5 City or Tox	Street and Number or vn, State)	Rural Route Number,
To the Hospital of within 24 hours aft To the Funeral D completely filled in	cal Ce	29a. Certifier 1 CertifyIng (Check only 2 Medical E	Physician: To the best xaminer: On the basis of	of my kno	owledge, dea	th occurred at the t	ime, date and place	, and due to the	cause(s) and manner	as stated.
thin 24 the H	Medical	one)  29b. Signature and title of certifier	and manner st	ated.		29c. Licen			29d. Date signed (Me	
3		> Clar	wdin			2	43121		05/26	109
		30. Name and address of person w	no completed cause of o	death (Iten	n 23a) (Type	, Print)	DIVE : BO	RTONS	ville, A	40 2086E
Sta	te	30. Name and address of person w  NURUL CHOL  31. Date filed (Month, Day, Year)	32. Regist	rar's Signa	ature	y y r v v	~- 0 / //4		- / /	2 2000
Registr	ar	MAY 28	2009 Breeze	1	1. So	and				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2 Day Physician Ronald William Haslam 2009 3:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 29 Harbormist Court Ocean Pines Worcester 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year 6/26/1947 Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Days Hours Min 215-46-5371 61 PA Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinations to rediffied at Director 1 ☐ Yes 2 No MD Worcester Ocean Pines 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29 Harbormist Court 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1∐Yes 2∏XNo δ Specify. Specify 3 ☐ Widowed 4 ☐ Divorced white Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Police Officer Law Enforcement t of Health and Mental Hy fitem 27 is marks 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Haslam Margaret Faye McNulty 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kristin Haslam / wife 29 Harbormist Court, Ocean Pines, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Cape Henlopen Crem. 5/27/2009 4 ☐ Donation 5 ☐ Other (Specify) Frankford, DE 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Burbage Funeral Home <u>108 Will</u>iam St., Berlin, MD 21811 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of lying shick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death such as cardiac or respiratory arrest, Immediate Cause (Final Physician m 0 disease or condition resulting in death) /Medical Due to ( r as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate 2 X No 1 ☐ Yes 2 ☐ No 1 □Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \( \text{Nursing Home} \) 1 Nursing Home \( 5 \) 1 Nesidence \( 6 \) Other (Specify) 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Medical 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature 29d. Date signed (Month, Day, Year)

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State Registrar 31. Date filed (Month, Day, Year)

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30. Name and address of pe

32. Registrar's Signature

Dreve B. Sparke

son who completed cause of death (Item 23a) (Type, Print)

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E CARRILLST

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May 2009 1325 P M Virginia Bendt Hillyard 27, 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Upper Chesapeake Medical Center Harford Bel Air If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Hours 1 □ M 2 🗓 F 214-40-2402 87 July 16, 1921 New York Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ∐Yes 2 🕅 No Maryland Harford Street 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3708 Grier Nursery Road 21154 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ∐Yes 2 XX No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1∐Yes 2M∑No Specify: Specify: 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George William Bendt Myrtle Irene Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Claudia Beck/Niece 9746 Gingerwood Drive, Ellicott City, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State May 30. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Friends Burial 4 ☐ Donation 5 ☐ Other (Specify) 2009 Calvert, MD Ground Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 21. Signature of Funeral Service Licensee 21921 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepres Due to (or as a consequence of) ellulit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of). 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown

sician and burial-tran Hillyard Virginiam 80043650 Division of Vital Records, P.O. Box 68760 attending physician I or Attending Physician; after death.
Director: After this certifica Hospital 24 hours a To the Hosp within 24 hor To the Fune completely fi

**Physician** 

/Medical

Director

Funeral

Completed by

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Examiner

**Funeral** 

Director

ed other than "natural", or items 23a or 28a-f show event, it a Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If item 27 is marked other the any lijury or other traumatic event, it and once.

Physician

/Medical

**Examiner** 

Maryland

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Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23d. Date of delivery Month Day Year						
ed by Pl	Part II. Other significant conditions of		acco use contribute to the cause of death?  s 2 \( \text{No} \) 3 \( \text{Probably} \) Y \( \text{Unknown} \)					
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ation:	27. Manner of Death 1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)  28b. Time of Sec. Injury at Work?  M 1 □ Yes 2 [		w injury occurred				
Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (St. City or Town	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
edical (		niner: On the best of my knowledge, death occurred at the time, date niner: On the basis of examination and/or investigation, in my opinion, on and manner stated.						

29c. License number

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29d. Date signed (Month, Day, Year)

27 200

Registrar

State

29b. Signature and title of certifier

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DAV. D

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 9 2009 ▶

32. Registrar's Signature

DHMH 17 Rev 1/2001

P.O. Box 68760.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Evelyn J. Nixon Hinton May 23 2009 13:30 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Prince George's Clinton 5. Social Security Number If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕅 F Months Days 66 Director 238-68-7576 14, 1942 North Carolina Dec. Usual Residence of Decedent show 10h Counts 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Exemples reast by notified at Director 1XYes 2 □ No Maryland Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7905 Canberra Place 20735 United States death v 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any finury or other traumatic event, the Modies Experiment 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No \$ If Yes, Give Year or Dates: Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Teacher Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lenora Sanders William Ed Nixon Jr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clinton, Maryland 20735 7905 Canberra Place Oscar Hinton/ Husband 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Selma Memorial 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State June 1, 2009 Selma, NC 4 ☐ Donation 5 ☐ Other (Specify) Gardens 21. Signature of peral service License 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Rd. N.E. Washington, DC 20019 23a. Part1. Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ItEMORRITAGE GASTROINTESTINAL /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 🖾 No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page To the Hospital or Attending Physician: The performed? certificate 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification; To After th funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 24 hours after death. le Funeral Director; A bletely filled in by the fi death. 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

State Registrar (Check only one)

29b. Signature and title of certifier

8700 Central Ave. Suite 301 Landover, Maryland Musa Momoh, MD 32. Registrar's Signature 31. Date filed (Month, Da MAY 2 8 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D 52900

29d. Date signed (Month, Day, Year)

20785

115-26-2009

			For State Registrar	Please	State of Ma		d / Depa	artmer	nt of H			-		e	185	817
ı	Physicia		1. Decedent's Nam		ast) EAN	HOFE	FLER					ate of D Jonth Y	eath	ay 2009ar	3. Time o	
•	Medic/ Examin				ive street and number)			4b. City.	Town, or	Location of Death				c. County of Dea		
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F	uneral		5. Social Security N	lumber 6.	Sex 7. Ag		ast birthday)	If Unde Months	r 1 Year	If Under 24 Hrs. Hours Min.	8. 0	ate of B	irth	9 Ri	rthplace <i>(State</i> country) LIN	or Foreign
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and	W		Usual Residence of 10a. State	10b. County		10c. City	. Town or Lo	cation							10d. Inside (	City Limits
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deal	ems	ıner	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S	S. 13. \			ispanic Origin? (S an, Mexican, Puert	pecify o Rica	Yes or N		14. Race - Am Black, Whi		
s afte	or if	by Fi	1 ☐ Never Marr 3 🛣 Widowed	ied 2☐ Married	1 □Yes 2 □ I If Yes, GiveX	No		1 □ Yes		Specify:				Specify: BI		
hound	tural al Ex		3 🔼 Widowed	15. Decedent's I	Year or Dates:		16a. Dece	dent's Hsu	al Occun	ation			1 16b	Kind of Business		
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ath ce	ttendi or use	an/I	23b. Was deceden in the past 12		23c. If yes, outcome 1 ☐ Live birth	2 Fetal	death 3	∃Ectopic <sub>I</sub>		у				23d. Date of de	elivery Day	Year
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To the Hospital or within 24 hours afte	To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	Medical C	29a. Certifier (Check only one)	1 Certifying F 2 Medical Exa	Physician: To the best aminer: On the basis o and manner sta	f examinat	wledge, death tion and/or in	h occurred vestigation	at the ti	me, date and place pinion, death occu	e, and ourred a	due to th	e cause e, date a	(s) and manner and place, and du	as stated. le to the cause	(s)
To th withir	To th	Me	29b. Signature and	title of certifier	00	~ /		29		e number			29d. E	ate signed (Mor	nth, Day, Year)	
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2-	5		30. Name and addr	ress of person who	o completed cause of d D 14300 GA	eath (Item LLANT	23a) (Type, FOX I	Print)	124	BOWIE, M	D 2	0715				
	Sta	te	31. Date filed (Mon	th, Day, Year)	22 Pagistr	ar'e Signat	TURO							<u> </u>		
	Registra		MAY 28	2009	Enera B.	fa	Ken									

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 12:07AM Pearline Hill May 26, 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince Georges Community Hospital Cheverly, Maryland If Under 1 Year If Under 24 Hrs. 8 Prince George's 5. Social Security Number If Under 1 Year 8. Date of Birth June II, 1935 7. Age (In yrs. last birthday) 73 Yrs. Birthplace (State or Foreign Country) Days Hours Min. 1 □ M 2 □ X F Yrs. Gastonia, NC 122-30-0292 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√Yes 2□No Washington, DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4296 Southern Avenue, SE 20019 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Day Care Service Provider</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elgin Fewell Lizzie Wilson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leon Hill (Husband) 4296 Southern Avenue, SE, Washington, DC 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Harmony Memorial Park June 2, 2009 4 ☐ Donation 5 ☐ Other (Specify) Landover, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility

Physician /Medical Examiner

burial-trar

attending p for use as t

signed by t

funeral director

n 24 hours after death. le Funeral Director: A letely filled in by the fu

within 2.

**Physician** 

Examiner

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It of Notice Examiner must be rediffed at once.

/Medical

DC

Director

Funeral

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Completed

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Lamy & Si	Cormons	Pope Funeral Home Washington, DC 2	s, 2617 Pen 0020	nsylvani	a Ave,SE	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death)	a cerebro vascular accident				Oriset and Death	
	Due to (or as a consequence of	of):				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):					
	С				<u> </u>	
	Due to (or as a consequence of	f):				
IF FEMALE:						
23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23d. Date of d  1  Live birth 2  Fetal death 4  Pregnant at time of death 9 Unknown    23d. Date of d  Month			ivery Day Year		
Part II. Other significant conditions of	ontributing to death but not resulting in	the underlying cause given in Part I.			the cause of death?	
			24a. Was an autopsy performed?	death?	topsy findings available completion of cause of	
25. Was case referred to medical examiner?	26. Place of Death (Check only one)  Hospital: Other:					
I les ZMINO	Inpatient 2 ER/Out	patient 3 DOA Other: 4 Nursing	Home 5 ☐ Residence	6 ☐ Other (Spe	cify)	
27. Manner of Death  1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year) Ir	ime of 28c. Injury at Work?  M 1 □ Yes 2 □ No	28d. Describe how inj	28d. Describe how injury occurred		
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier 1 X Certifying Physical Check only one) 2 Medical Example 1	ysician: To the best of my knowledge liner: On the basis of examination and and manner stated.	death occurred at the time, date and platfor investigation, in my opinion, death occ	ce, and due to the cause curred at the time, date a	(s) and manner as and place, and due	s stated. to the cause(s)	
29b. Signature and title of certifier		29c. License number	29d. E	d. Date signed (Month, Day, Year)		
Kau	R Brooks	0004918	83 5	5/26/0	29	

Hospital or Attending Physician: The law requires that the death certificate be execute

Division of Vital Records, P.O. Box 68760,

State Registrar KAREN R. BROOKS

HOSPITAL DRIVE CHEVERLY, MARYLAND20785 31. Date filed (Month, Day, Year) MAY 2 9 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Walter Edwin Harris, Jr. May 2009 27, 9:40 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Villa Rosa Nursing Home Mitchellville Prince George's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 12/17/1914 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days 167-01-8379 1 √ M 2 □ F 94 Director PA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Exercities must be notified at MD  $\mathbf{PG}$ Y☐Yes 2☐No Howie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12620 Kavanauch Lane 20715 U.S.A. Funeral and 2 should be filed within 72 hours after death leath and Mental Hygiene.

m 27 is marked other than "natural", or items 23 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married ∑Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give 1943 Year or Dates: 1944 1 ☐ Yes 2 🔀 No Completed by Specify: Black 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Emineerer Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be if Health and Menta Walter E. Harris, SR. Helen Bessley ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail M. Hannis — Daughten 11211 Joyceton Drive; Upper Marlboro, MD 20774 Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veteran Cemtery | 06/05/2009 Cheltenham, Maryland 22. Name and Address of Facility Freeman Funeral Services 21. Signatura of uner 4594 Beech Road; Temple Hills, MD Part 1. Enter the disease, or con shock or heart failure. List only ligations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between nset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MI /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed Exam sician and burial-tran Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical as nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 autopsy or Attending Physician: The after death.
Director: After this certificate his 1 ☐ Yes 2 🖾 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Hospital 29a. Certifier 🚾 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical npletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check or within 24 one) 29b. Signature le of certifier 29c. License number 29d. Date signed (Month, Day, Year) 32261

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State

DHMH 17 Rev 1/2001

Name and address of person who co

. Date filed (Month

dicause of death (Item 23a) (Type, Print)

ALLAPOLIS LA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician LEO HANSBERRY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Prince Georges 600 Largo argo Age (In yrs. last birthday) Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day 9. Birthplace (State or Foreign Security Number **Funeral** 1**X**M 2□ F Hours Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Department of Health and Mental Hygiene. Important: jor items 23a or 28a-f show any injury or other traumatic event, the Mydical Exactions in the Institute of any injury or other traumatic event, the Mydical Exactions in the Institute of any injury or other traumatic event, the Mydical Exactions or other traumatic events. Prince Georges 1 Yes 2 No Director APITOL HEIGHTS 10g. Citizen of What Country? US Deanwood DR Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ∐Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Black 1 □Yes 2 No Specify. Be Completed by 3 ☐ Widowed 4 💆 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) AINTER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN UNKNOWN ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHIPLEY CAPITOL HEIGHTS MD20743 WOLFE-COUSIN 20b. Place of Disposition (Name of cemetery, crematory or other place)

ARDENT CREMATORY MAY 30, 2009 HANOVER, MD 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. 22. Name and Address of Facility MIDATLANTIC CREMATION SOCIETY 21. Signature of Funeral Service 7829 Belle Point Dr. Greenbelt, ND 20170 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician HERD NECK CANCER montho disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** LUNG CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of). or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760. attending physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) P.O. 9 Unknown ture: Auter this certificate has been signed by the funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 □Yes 2 □ No 2 Accident within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 29a. Certifier 😢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOBHAN MATHEW 3048 MITCHELLVILLE ROAD, BOWIE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 2 9 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician Year HUDSON :45 AM DONALD V. 05 2009 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospic Lake (a) oastal at the 1:56 W M. CO a If Under 1 Year | If Under 24 H/s. 5. Social Security Number 8. Date of Birth (Month, Day, OCT. 4, 9. Birthplace (State or Foreign **Funeral** 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) Months Days MARYLAND Yrs. Director 217-30-9818 1932 76 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ral", or items 23a or 28a-f st Evan incr., ust be notified 1 ☐ Yes 2X No Directo MARYLAND WICOMICO WILLARDS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21874 7625 NEW HOPE ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Itimore, Maryland 21215-0036 If Yes, Give Year or Dates: KOREAN 1 □Yes 2X No Š Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced "natural" Completed er than "natur 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) POULTRY 12 POULTRY GROWER is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BEATRICE LEWIS **VELETUS** HUDSON 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra once. 7625 NEW HOPE ROAD, WILLARDS, MARYLAND 21874 E. LEE HUDSON/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 5/27/09 DELMAR, DELAWARE 4 ☐ Donation 5 ☐ Other (Specify) CREMATORY OF DELMARVA 21. Sig / tury f Foneral Service Licens 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Immediate Cause (Final disease or condition resulting in death) **Physician** Metasta /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, Que to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the death certificate be executed Exami and burial-tran Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Ye ar Day 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown s been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 □ Yes 2.0 1 ☐ Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 5 Pending investigation death. 1 🗆 Yes 2 🗆 No after death 2 Accident pletely filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated.

State Registrar 29b Signat

31. Date filed (Month, Day, Year)

MAY 28 2009

address of person who completed cause of death (Item 23a) (Type, Print) muelle

29d. Date signed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Elston Gerald Hovatter, Sr. 11:21A<sup>M</sup> May 20, 2009 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 205 West Church Street Hebron Wicomico 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Min. Hours 1 X M 2 □ F Director 217-16-9279 89 Sept. 22, 1919 West Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, it of Medical Examinations to printed at 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits Director 1X Yes 2 No MD Wicomico Hebron 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 205 West Church Street 21830 U.S.A. by Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ⊠Yes 2 □ No 1941—
If Yes, Give
Year or Dates: 1945 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. 3 Nidowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pipefitter Nylon Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles E. Hovatter ပ Ella Agnes Burns 19a. Informant's Name/Relationship (Type. Print) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlene Hovatter Armentrout 1030 Ellegood Street Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hebron Cemetery May 23, 2009 Hebron, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Short Funeral Home 13 East Grove Street Funeral Delmar, DE complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1 Enter the disease, or Approximate Interval Between Onset and Death shock or beart failure. List only one c Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) a Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or Ifigury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a ☐Yes 2☐No 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 2 1 ☐ Yes 1 Yes 25. Was case referred o medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Pother (Specify) NSPICE 2 No ဥ 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Mann of Death Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 | Natural 2 | Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No filled in by the 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only within 2 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number son who completed cause of death (Item 23a) (Type, Print) ASTERN SHINE OR SAUSBUKTADZBOU 31. Date filed (Month, Day, 32 Registrar's Signatur Year) State 26 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death and Day Month **Physician** 5:37 PM 2009 George Konald /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Washington Hagerstown If Under 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 2□ F Months Days Hours **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinating it ust be notified at 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral filed within 72 hours after death Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Pyes 2 No If yes, Give Year or Dates: /955-63 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Washington Whitmore ၉ Mildred Irene George 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Falling Waters Sheila wife Harbor Court WV Jones 20b. Place of Disposition (Name of cemetery, crematory or other place Comberland Velley 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 A Cremation 3 N Removal from State 12009 Naynesboro 4 Donation 5 ☐ Other (Specify) 21. Signature of Fun ral Service Licens 22. Name and Address of Facility Grove-Bowersex Funeral Home Inc Broad St. Waynesboro 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** stage and eli resse /Medical Due to (or as a cons a uence of): Examiner Abother Tive moure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed neumonde and Due to (or as a consequence of): P.O. Box 68760, the attending physician the dria Physician/Medical Ileus IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy this certificate 1 ☐Yes 2 ☐ No 1 Tes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2⊠No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 124 hours after death.

e Funeral Director: After thioletely filled in by the funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number De oul 06/02/04

SH-5+1

State

31. Date filed (Month Registrar

KAIKA MO 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760. after death.

Maryland 21215-0036

Baltimore,

of Vital Records, Division completely filled in by Hospital

Registrar

Sobhan A. Mathew, M.D. 3048 Mitchellville Rd., Bowie, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

and manner stated

29a. Certifier

29b. Signature and file of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D47604

29d. Date signed (Month, Day, Year)

May 26,2009

20716

Certificate of Death

	Physic /Medi		Milton	Jorda	n			May 25,			
Ì	Exami	ner	4a. Facility Name (If not institution, Holy Cross Hosp		er)	4b. City, Town, c	r Location of Deal	th	4c. County		
	Funeral Director		254-20-6458	. Sex 7.7	Age (In yrs. last birthday, 86 yrs.	Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day, 12/4/192	Year)	9. Birthp Coun Ather	elace (State or Foreign try) ns, Georgia
	Maryland a-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  D • C •		10c. City, Town or Lo		shingtor	n		10	0d. Inside City Limits 1 ☑Yes 2 ☐ No
	h with the 23a or 28 st be not	Funeral Director	10e. Street and Number 6008 7th Stree	t, N.W.		10f. Zip Code	20011	L 10	og. Citizen of V	What Coun	try?
9600	within 72 hours after death with the Maryland iene. than "natural", or items 23a or 28a-f show the Modical Extrainer nast be notified at	5	11. Marital Status  1 □ Never Married XX Marrier 3 □ Widowed 4 □ Divorced	If Yes, Give Year or Dates	No s:	Was Decedent of I- If Yes, specify Cub 1 □ Yes	Specify:		Specify	/.	etc. Lack
Baltimore, Maryland 21215-0036	d within 72 giene.	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed)  College (1-4o	r 5+) (Give	edent's Usual Occup e kind of work done DO NOT use retire fset Pres	during most of wo d)	rking	16b. Kind of Bu		epartment
yland	ould be filed Mental Hy rarked othe ratic event,	To Be C		Jordan			18. Mother's Na	me <i>(First, Middle, N</i> Julia Dav		,	
e, Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Modeal Examiner is ast be notified at once.		19a. Informant's Name/Relationship Lillian A. Jorda	. Washing	imber, City or Town, State, Zip Code) Ington, D.C. 20011						
timore			20a. Method of Disposition  1  Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spe	cify)		≥ 1 <b>,</b> 2009		wood	, Maryland		
Ball	permit, Pag Departmen Important; any injury once.		21. Signature of Funeral Service Lie	ensee				arshall's N.W. Wash			
	death certificate be executed  e attending physician and dror use as the burial-transit		23a. Pari Fine the disease, or co sh of heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a. Metabo	ed the death. Do not en line.  1ic Acidosi as a consequence of):		ng, such as cardia	c or respiratory arre	est,		Approximate Interval Between Onset and Death
		cal Examiner	Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Septic Due to (or a Pneumo	Shock as a consequence of):						
		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	у			te of delive	ery Day Year	
rds, P.	law requires that the as been signed by the 2 should be detached	þ	Part II. Other significant conditions Pancreatic		but not resulting in the u	inderlying cause giv	en in Part I.				ne cause of death?
<u> </u>	The ate h page	Completed	Coronary Ar Dementia, D			·e		24a. Was ar autopsy perform 1 □ Yes 2	red?	prior to cor death?	psy findings available mpletion of cause of
of Vita	hysician; Th this certificate al director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2√2No	The same of the sa	tient 2 ☐ ER/Outpatier		er: 4 🗌 Nursing H	ath (Check only one	9)		
Division	To the hospital or Attending Physician; within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	27. Manner of Death  13 Natural 2	be 28e. Place of li	njury 28b. Time o lnjury njury - At home, farm, stretc. (Specify)	M 1 🗆	y at k? Yes 2 □ No	28d. Describe hor 28f. Location (Str. City or Town	eet a <i>nd Numb</i>		l Route Number,
	ne Hospit in 24 hour he Funera pletely fille	Medical (	29a. Certifier (Check only one)  Certifying  Certifying  Condition   Physician: To the bes aminer: On the basis and manners	st of my knowledge, deat of examination and/or in stated.	th occurred at the tin	me, date and plac ppinion, death occi	e, and due to the ca urred at the time, da	ause(s) and ma	anner as st	tated. the cause(s)	
D	To the common co	W	29b. Signature and title of certifier	16			e number 7901	29	Od. Date signed	d (Month, 1 5/0	Day, Year)
R	8		30. Name and address of person whe Winnifred Lee,	MD 1500	Forest Glen	Road Si	ilver Spi	ring, Md.	20910		
	Sta Registr		31. Date filed (Month, Day, Year)  NAY 2 9 2009	Several ,	trar's Signature	•					

		-	State of N  State Registrar	faryland /		rtment of H tificate of D			giene Reg. No.2	09	18826	
	Physicia		1. Decedent's Name (First, Middle, Last) JOHN JANEY					2. Date of Dea Month MAY 21	Day 2009	Year	3. Time of Death	
***	/Medic Examin Funeral	er		r) Age (In yrs. last b	irthday)	4b. City, Town, or CHEVERLY	If Under 24 Hrs.	8. Date of Birt (Month, Da	4c. Count PRING	CE GE		
п	Director		219-36-8159 ¥□ M 2□ F	68	Yrs.	Months Days	Hours Min.	11-22-1		1	LAND	
	Maryland -f show	tor	Usual Residence of Decedent	10c. City, Tov							10d. Inside City Limits 1   Yes 2  No	
	th the l	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Co	intry?	
	ath wi		9600 BALD HILL ROAD	at Ever in II C	12 1	20721 Was Decedent of Hi	spanic Origin? (Sn	ecify Yes or No		S.A.	rican Indian,	
36	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show deal Evan her must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 1 Married  3 □ Widowed 4 □ Divorced  12. Was Deceder Armed Force: 1 □ Yes 2 If Yes, Give Year or Dates	<b>₹</b> No 3?		fYes, specify Cuba 1 □Yes 🏋 No	Specify:	Rican, etc.)	Spec	ack, White		
21215-0036	within 72 hou ene. than "natura in "nd call E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-40		(Give life. l	dent's Usual Occupa kind of work done of DO NOT use retired E TAX SPE	luring most of work )	ing	16b. Kind of Business/Industry PRIVATE		ndustry	
	filed within Hygiene. <b>other than</b> " ent, the "		12th 17. Father's Name (First, Middle, Last)	11	- COM	L IAA SIL	18. Mother's Name	e (First, Middle				
anc	2 should be filed w n and Mental Hygie is marked other t raumatic event, th	To Be	VERNON JANEY				ETHEL COA	ATES				
Maryland	shoul and M s marl	۴	19a. Informant's Name/Relationship (Type. Print)			ng Address (Street a						
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Baltimore,			20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)	te HARMO	lery, crer NY 1	MEMORIAL	05-29	9-2009	LANDOV	ER, N	AD	
Balt	permit Depart Import any Inj once.	١.	21. Signature of Funeral Service Licensee  22. Name and Address of Facility JB JENKINS FUNERAL HOME  7474 LANDOVER RD LANDOVER, MD 20785  232. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate									
	Physician /Medical Examiner	ner	23a. Part1. Enter the disea e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)  Due to (or as a consequence of):  Due to (or as a consequence of):								interval Between Onset and Death	
,8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical Examiner	that initiated events C.	as a consequenc	e of):							
O. Box 6	the death certific y the attending p ched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcoment of 1 □ Live birt of 1 □ Live			Date of de Month	livery Day Year					
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Division of Vital Records,	. The law requir cate has been si page 2 should I	Completed						perl 1 □ Yes	opsy formed? 2 12 No	prior to death?	utopsy findings available completion of cause of s 2  No	
Vita	sector,	Be	25. Was case referred to medical examiner?	atient 2 ER/	Outnotio	nt 3 🗆 DOA Oth	26. Place of Dea		one)	Other (So	acifu)	
on of	ding Phys h. After this funeral di	tion: To	27. Manner of Death 28a. Date of		outpatie D. Time o Injury	of 28c. Inju	4 🗆 Nursing i		how injury occ		July /	
Divisi	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification: To		Injury - At home, , etc. (Specify)	farm, st	reet, factory, office		28f. Location City or To	(Street and Nu own, State)	mber or F	tural Route Number,	
	ne Hospita n 24 hours ne Funera pietely fille	Medical C	29a. Certifler (Check only one)  1 Certifying Physician: To the base and manne	is of examination	dge, dea and/or i	th occurred at the ti nvestigation, in my	ime, date and place opinion, death occu	e, and due to th	e, date and pla	ce, and du	e to the cause(s)	
	To the vithing to the complete of the complete	Ž	29b. Signature and title of certifier			29c. Licens	3594	7	5	26	th, Day, Year)	
i K	25		30. Name and address of person who completed cause	of death (Item 23	a) (Type	Print)	clor un	4 420	2 Mita	teres	nue MO,207	
	St. Regist	ate rar		gistrat's Signature				1				

State of Maryland / Department of Health and Mental Hygiene For State Registras 1-Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** MAY 21, 2009 10:00P **JACKSON** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** PRINCE GEORGE HOSPITAL PRINCE GEORGE CHEVERLY 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number Sex M 2 ☐ F **Funeral** Months Days Hours Min. 65 01-14-1944 WASHINGTON. DC Director 220-44-4550 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any linity or other traumatic event, it a Mental Event and 2008. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location MD 1 XYes 2 No PRINCE GEORGE CAPITOL HEIGHTS Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5809 BURGUNDY ST UNIT 2 20743 U.S.A. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 ◯XNo Specify Specify: BLACK þ 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2yrs ENGINEER PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be EARL D. JACKSON SARAH HACKLEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3823 64th AVENUE #1 LANDOVER, MD 20785 SABRINA J. COATES/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State HARMONY MEMORIAL CEME 05-30-2009 LANDOVER, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JB JENKINS FUNERAL HOME 21. Signature of Funeral Service Ligensee 7474 LANDOVER RD LANDOVER, MD 20785 or complications that caused the death. Do not enter the moth of dying, such as cardiac or respiratory arrest test only one cause on such line. Approximate Interval Between Opeet and Death 23a. Part 1. Enter the disease Immediate Cause (Final disease or condition resulting in death) Physician JW14 /Medical Due to (or se a consequence of) Examiner espe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a contequence of Examine the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) s been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an as S autopsy page perform 2 2 No 1 □Yes 2 X No After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending within 24 hours are occurred to the Funeral Director Aff 1 ☐ Yes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 30. Name and Indress of person who completed cause of death (Item 23a) (Type, Print) AKras 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 2009 Η. Jones /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HICOMICS 30/13bH/4 ROGIANAL If Under 1 Year | If Under 24 Ars. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Social Security Number **Funeral** Year) Days 1 X M 2 □ F 83 4-2-1926 Maryland 218-20-6928 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2X No Funeral Director Pittsville MD Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6705 Friendship Road 21850 USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 X Yes 2 □ No 194
If Yes, Give
Year or Dates: 194 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1944 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🔯 No Specify: White þ 3 Widowed 4 Divorced 1946 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Board of Education Manager of Maintenance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jones Gartice 2 Amos 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6705 Friendship Road, Pittsville, Maryland 21850 Annie Lee Jones - Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5-30-2009 Pittsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Pittsville Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Bounds Funeral Home Salisbury, Maryland 21804 Ε. Main Street, 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only the cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Jo the Funeral Director: After this certificate has been signed by the attending physician and Affichetely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy Ye ar in the past 12 months? Month Dav 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2⊟No 2 No 1 ☐ Yes 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊟No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 ☐ Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Registrar DHMH 17 Rev 1/2001 29a. Certifier

29b. Signature and title of certifie

Medical

State

of geath (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

ISTERN STOPE DR, SACISTS VAY MDZ1814

		For State Registrar	State of Marylan		rtment of F tificate of I		•	giene Reg. No	009	18829		
Physici		Decedent's Name (First, Middle, Last Edward Ray Kast	_				2. Date of De Month May 2	Day	Year	3. Time of Death 3:00 a M		
/Medio		4a. Facility Name (If not institution, give		-		r Location of Death		4c. C	ounty of Death			
Funeral Director		5. Social Security Number 6. Se 338-01-0164	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Oct. 2	ay, Year)	9. Birth Cou	nplace (State or Foreign Intry) llinois		
h the Maryland or 28a-f show	irector	Usual Residence of Decedent		, Town or Lo				10d. Inside City Limits 1 □ Yes 2 🗷 No  10g. Citizen of What Country?				
paritimiore, Maryjania ZIZIS-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm "nicial Erain invariant by netting at once.	by Funeral Director	3124 Gracefield F  11. Marital Status  1 Never Married  Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Xfes 2 ☐ No	1	Vas Decedent of H	904 lispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)		USA  4. Race - Amer Black, White Specify: WI			
led within 72 hou dyglene. "her than "naturant, in Widdelland".	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		(Give	OO NOT use retired	during most of worl		US D		ndustry f Treasury		
/fall(d	To Be	17. Father's Name (First, Middle, Last)  Arthur Ray Kasto	orf			Gertrude	,	,	urname)			
, INICIT,	·	19a. Informant's Name/Relationship (7) Dorothy Hammon Kas	•	1	-			-		Spring, MD		
dittifficial control of control of control of the partment of the portant: If item y Injury or othe control of		20a. Method of Disposition  **A** Burial 2 □ Cremation 3 □ i  4 □ Donation 5 □ Other (Specify	Removal from State	emetery, cren	sition (Name of natory or other place Heaven Ce	ce) ¦	Date May 27 2009		ation - City or T			
Dalti permit. Departm Importa any Inju		21. Signature of Funeral Service Licens  23a. Part 1. Enter the disease, or comp	J.	5	00 Unive	ss of Facility Collins csity Blv	Funera	l Hom Silve	e Inc.	Approximate		
Physician /Medical		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	nne cause on each line.  a. Congestive I  Due to (or as a consequ		Failure					Interval Between Onset and Death 10 years		
ficate be executed me physician and sthe burial-transit	dical Examiner	Sequentially list conditions, fary, learning to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Coronary Art  Due to (or as a consequence)  Due to (or as a consequence)	ience of):	isease					20 years		
Physician: The law requires that the death certific this certificate has been signed by the attending praid director, page 2 should be detached for use as a	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d 9 ☐ Unknown	death 3	Ectopic pregnanc Other (specify)	у		23	3d. Date of deli Month	ivery Day Year		
w requires that been signed be should be deta	þ	Part II. Other significant conditions co	ontributing to death but not resu	ulting in the ur	nderlying cause giv	en in Part I.				the cause of death?		
iclan: The law recertificate has be ector, page 2 sho	e Completed	25. Was case referred to medical				00 Blass of Day		psy ormed? 2 No	prior to death?	topsy findings available completion of cause of 2 □No		
ding Physician: th. After this certifical funeral director,	To B	examiner? 1 ☐ Yes 2 🚰 No	Hospital: 1 ☐ Inpatient 2 ☐			26. Place of Dea er: 4 ☐ Nursing H	ome 5 Kes	idence 6		cify)		
To the Hospital or Attending Physicial Section 24 hours after death.  To the Funeral Director: After the completely filled in by the funeral	Certification:	27. Manner of Death  1 Natural 5 Pending  2 Accident investigation  3 Suicide 6 Could not be	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury		ryat k? Yes 2 □ No	28d. Describe					
vital or At urs after o ral Direct		4 Homicide determined	building, etc. (Specify	v) 			City or To	wn, State)		ıral Route Number,		
ne Hosp n 24 hou ne Fune pletely fi	Medical	29a. Certifier 1 ☐ Certifying Phyone) 2 ☐ Medical Exam	ysician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, deati tion and/or in	n occurred at the ti vestigation, in my o	me, date and place opinion, death occu	red at the time	cause(s) , date and p	and manner as place, and due	s stated. to the cause(s)		
To the comp	Me	29b. Signature and title (certifier	Minto		29c. Licens D2	e number 24093			27, 200			
J V -		30. Name and address of person who commark Parkhurst,	ompleted cause of death (Item MD 3110 Gra	123a) (Type,	Print) Ld Road,	Silver S	pring,	MD 20	904			
Sta Registr		31. Date filed (Month, Day, Year)  MAY 2.8 20	32. Registrar's Signa	ture -	a Kad							

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

		-	For State of Maryland / Department of of Mary	rtificate of Death	Reg. N	0000 10000					
	Physicia	an	1. Decedent's Name (First, Middle, Last)  Vera Virginia Kretzer		2. Date of Death May 29,	3. Time of Death 11:50a M					
	/Medic	al	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death					
1	LAAIIIII		16505 Virginia Ave.	Williamsport	O Date of Dieth	Washington					
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 214-42-1426 1 1 M 2 XF 86 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 4 – 30 – 192	9. Birthplace (State or Foreign Country) Clear Spring					
	0		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo	ocation		Maryland 10d. Inside City Limits					
	Maryla i-f sho	tor	MD Washington Clear S	pring		1 ☐ Yes 2 X No					
	n with the	Funeral Director	10e. Street and Number 13324 Blairs Valley Road	10f. Zip Code 21722	_	Citizen of What Country?					
920	be filed within 72 hours after death with the Maryland tall Hygiene. At the Wayland of other than "natural", or items 23a or 28a-f show event, the Marifest Exp. citis of count to in villand at		1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto 1 □Yes • No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: white					
9500-6121		Completed by	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired) armer	king 1	Kind of Business/Industry  lairy farm					
⊑	should be filed within and Mental Hygiene. marked other than imatic event, the Market and the Market than imatic event, the Market than and the Market than th	To Be Co	17. Father's Name (First, Middle, Last) Lawrence Rowland	18. Mother's Nam Blanc	ne (First, Middle, Maid n Carba						
Ë	nd 2 s alth ar 27 is rtrau			ng Address (Street and Number or Ru 11 Dover Dr. H	agerstowr	n, MD 21742					
Ψ	Pages 1 ar nent of Hea ant: If item ary or othe		20a. Method of Disposition  **D Burial 2  Cremation 3  Removal from State 4  Donation 5  Other (Specify)  20b. Place of Disposition cemetery, cre  **St. Pau**	osition (Name of matory or other place)  1 Cemetery 20	$\geq 2$ , C1	Location - City or Town, State Lear Spring MD					
Pair	permit. Pages Department of Important: If is any Injury or once.		21. So nature of Funeral Service Licensee 2  23a. Part 1. Enter the disease, or complication that caused the death. Do not en	2. Name and Address of Facility Donald Edwin T P.O. BOX 310 Cl	nompson E ear Sprir	Funeral Home, Inc					
	Physician /Medical Examiner		Shock, or heart-failure. List only one-cause on each line.	carcinomatosis	or respiratory arrest,	Approximate Interval Between Onset and Death  WELKS					
68760,	ificate be executed g physician and as the burial-transit	Sequentially list conditions, if any, boaring to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b.  Cus to (or as a consequence of):  Due to (or as a consequence of):  d.									
. Box	death certif e attending d for use as	Physician/Med		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery  Month Day Year					
ds, F	requires that the leen signed by th nould be detache	þ	Part II. Other significant conditions contributing to death but not resulting in the I	underlying cause given in Part I.		co use contribute to the cause of death?  2					
26 26	The la ate has bage 2	Completed	3		24a. Was an autopsy performed						
\ \ \ \	sician certifi irector	Be C	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No  Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie		ath (Check only one)	e 6  ☐Other (Specify)					
סר	ig Phy ter this neral d	n: To	27. Manner of Death 1 ☐ Manural 5 ☐ Pending (Month, Day, Year) Injury		28d. Describe how i						
DIVISION OF	or Attendir fter death. lirector: At n by the fu	Certification: To	2   Accident investigation   3   Suicide   6   Could not be   4   Homicide   determined   28e. Place of Injury - At home, farm, so   building, etc. (Specify)	M 1 □Yes 2 □ No treet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)					
	To the Hospital or Attending Physician: in 24 hours after death as after death To the Funeral Director: After this certifica completely filled in by the funeral director, to	edical Ce	29a. Certifier (Check only one)  1 ☐ Certifying Physician: To the best of my knowledge, dea (Check only one)  2 ☐ Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occ	e, and due to the causurred at the time, date	se(s) and manner as stated. and place, and due to the cause(s)					
	To the within To the comple	Mec	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)					
			Cypthia Kuttrei-Sands, 100	D471451	Ma	ay 29,2009					
人 人 J	4-3		30. Name and address of person who completed cause of death (Item 23a) (Type Cyntha Kutthan South Mark 1941)	Print)	1 Road	tag erstown,					
/ر	Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signature	MI MANUE MINI	II LOCKE	marylana dilita					

Registrar

JUN 0 1 2009 Jenus S. Jack

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** MAY 20, 2009 0255 A CAROLYN M. KOHLHAUS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** CAROLINE ENVOY OF DENTON DENTON Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 1 ☐ M 2 💢 🗲 215-14-4311 Director 89 DEC 11. 1919 MD Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location 28a-f show ir than "natural", or items 23a or 28a-f sho the Medical Examination rount to notified at XXYes 2 No Director MD CAROLINE DENTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with 420 COLONIAL DR. 21629 USA by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married Married Specify: WHITE Baltimore, Maryland 21215-0036 1 □Yes 2XXNo Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOSEPH HENRY SPARENBERG LYDIA GERMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important; If item 27 is any injury or other trau once. C. JAMES KOHLHAUS 531 WYE MILLS RD. QUEENSTOWN, MD 21658 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XXIII 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-23-2009 WOODLAWN MEM PARK EASTON, MD 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. Stroush Suph 200 S. HARRISON ST. EASTON, MD 21601 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician NEWMONIA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 No Day 5 ☐ Other (specify) 1 ☐ Yes P.0. signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown this certificate has been si al director, page 2 should l Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 ☐Yes 2 No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: Other: 

All Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After t commletely filled in by the funers 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier the Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and Name and addm ODMINGDAL Oo 8 State

Registrar

# Baltimore. Maryland 21215-0036

Division of Vital Records. P.O. Box 68760.

		Please Type or					-		_		
		1 - State State Registrar	of Marylar		artment of F rtificate of	lealth and N Death		giene Reg. No.	0000	19932	
		Decedent's Name (First, Middle, Last)					2. Date of De	ath	اسالية لية ليه	3. Time of Death	
Physicia Medic/		Ruth C. Klausing					May 22			4:45P™	
Examin	er	4a. Facility Name (If not institution, give street and n Charles Co. Nursing &		Contor		r Location of Death			County of Death	1	
Funeral		Social Security Number 6. Sex	7. Age (In yrs.	last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	rth	Co	nplace (State or Foreign	
Director	1	41 16 3160 1 M 2 XX	84	Yrs.			(Month, Da April	23,	1925 N∈	w Jersey	
ryland ihow	_	10a. State 10b. County	10c. Ci	ity, Town or Lo	ocation					10d. Inside City Limits	
the Ma 28a-f s	Director	MD Charles  10e. Street and Number		Wa	1dorf			10g Cit	izen of What Co	1 \( Yes \) No	
h with 3a or st be	al Dir	614 University Drive	9		2060	)2		_	ates		
er deat	Funeral	Armed F	cedent Ever in U	J.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	)-	14. Race - Ame Black, White		
filed within 72 hours after death with the Maryland Hygiene. Hygiene, the War death with the Maryland with the Maryleal Evantion must be notified at ent.	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes If Yes, G 3XXWidowed 4 ☐ Divorced Year or	2 XX hive XX Dates:		1□Yes 2□XX	Specify:			Specify: W	Mhite	
72 hours "natural"	eted	15. Decedent's Education (Specify only highest grade completed	)	(Give	edent's Usual Occup	during most of work	ing	16b. Ki	ind of Business/I	ndustry	
within iene.	Completed		(1-4or 5+)		DO NOT use retired usewife	d)		(	Own Home		
e filed al Hygi other vent, t	Be C	17. Father's Name (First, Middle, Last)		1.0	doewiie	18. Mother's Name	e (First, Middle				
ould b	To	Samuel Badger					n Cassi				
nd 2 sh lith and 27 is m		19a. Informant's Name/Relationship (Type. Print)  Ann Sanford, (Daughte	er)			and Number or Rui					
es 1 ar of Hea of Hea r other		20a. Method of Disposition	20b.			∞ June 1,			ocation - City or		
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: If item 27 is marked other than "natur any injury or other traumatic event, Ite. Medical once.		1 XX virial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)		ryland	Veterans	Cemetery		Che	eltenham	, MD	
permit Depar Impor any in	21. Signature of Funeral Strvice Licensee  22. Name and Address of Facility  Lee Funeral Home, inc.  Alexandria Ferry Road, Clinton, MD										
		23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the dea	th. Do not en	Alexandri ter the mode of dyi	a Ferry b ng, such as cardiac	or respiratory a	arrest,	on, MD	20735 Approximate Interval Between	
Physician		Immediate Cause (Final disease or condition	lerosal	erotic	Cardior	rascular	dislas	e		Onset and Death	
/Medical Examiner		resulting in death)  Due to	(or as a consec	quence of):	10+						
<b>1</b> 9 ±	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	(or as a consec	quence of):	MMA						
oe executed cian and urial-transit	Examiner	Cause (Disease or injury that initiated events c									
	= 1	d	7 (3) 40 4 00.100	4401100 01).							
entifical ling phy e as th	Physician/Medica	IF FEMALE:									
attend for us	cian/	23b. Was decedent pregnant in the past 12 months?	utcome of pregn e birth 2□Fet gnant at time of	al death 3	☐ Ectopic pregnand	СУ			23d. Date of del Month	ivery Day Year	
at the d by the tached	hysi	1 Yes 2 No g Unk									
The law requires that the death certificate ate has been signed by the attending phys bage 2 should be detached for use as the	ρ	Part II. Other significant conditions contributing to	death but not res	sulting in the u	ınderlying cause giv	en in Part I.			use contribute to ☐ No 3 ☐ Pr	the cause of death? robably 4 Unknown	
aw req as beel 2 shou	Completed						24a. Was		24b. Were au	topsy findings available completion of cause of	
: The cate h	Com						perfe 1 □Yes	ormed?	death?	_	
scertificate irector, pag	Be c	25. Was case referred to medical examiner?  1 Yes 2 No Hospital:	Inpatient 2	T SP/Outpotio	nt all DOA Oth	26. Place of Deat			€ □Othor (Coo		
ng Phy Iter this neral d	on: To		e of Injury onth, Day, Year)	28b. Time of			28d. Describe		6 ☐ Other (Spe ry occurred	спу)	
ttendii Jeath. Itor: A the fu	icatic	2 Accident investigation		ome form at		lYes 2□No	DOS Lagation	(C4===4==	ad Aliumbau og Di	ıral Route Number,	
alorA s after al Direc	Certification:	4 Homicide determined buil	ding, etc. (Spec	ify)	reet, factory, office		City or To			arai fronte Number,	
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, the funeral director director, the funeral director director, the funeral director director, the funeral director, the funeral director director, the funeral director director, the funeral director director director, the funeral director director director, the funeral director directo	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the 2 Medical Examiner: On the and ma									
To th withir To th comp	Me	29b. Signature and Me of certifier			29c. Licens	se number		29d. Da	ite signed (Mont	h, Day, Year)	
)		30. Name and address of person who completed car		m 00-1 /T		2574	Mo	(	>/26/	07	
DB3		Timothy Pace, MD, 1207				e #320, W	aldorf,	MD	20602		
Sta Registr		31. Date filed (Month, Day, Year) 32. MAY 28 2009	Pégistrar's Sign	B. A	barks						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death KIN 0855 (A) 2009 MYONG County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Age (In vrs. last birthday) 5. Social Security Number 1 🗆 M 2 🔀 44 28, 1964 South Korea 612-56-3354 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a State 10h. County XXYes 2 No Prince George's Bowie 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number South Korea 3010 Stoneybrook Dr. 20715 Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🄀 No 11. Marital Status 1 Never Married 2 Married Yes Give 1 Yes 2 No Specify: Asian 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mi Wun Lee Suk Chun Kim 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 20715 Bowie, MD 3010 Stoneybrook Dr. Min Sik Yu / husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State Lakemont Mem. Gards. 5/26/2009 Davidsonville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Lig 6512 NW Crain Hwy. Bowie, MD ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest e. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease shock, or heart failure. Immediate Cause (Final Sepsis disease or condition resulting in death) r as a consequence of breast Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month in the past 12 months?

1 Yes 2 No
9 Unknown Dav Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 Yes Yes 2) 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 1 ☐ Yes ✓ No 2 ER/Outpatient 3 DOA 6 Other (Specify) 1 Inpatient 28a. Date of Injury (Month, Day Year)

**Physician** /Medical **Examiner** 

Important: If any Injury or once.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

ò

Completed

Be

0

MD

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
nt: If item 27 is marked other than "natural", or items 23.

Maryland 21215-0036

Saltimore,

page 2 should

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

attending physician and for use as the burial-tran Physician/Medical gned by the atter be detached for 3 Be ၉

Completed Certification: Medical

27. Manner of Death

Natural
2 Accident

3 Suicide

29a. Certifier

4 Homicide

(check only

29b. Signature and title of certifier

or Attending Physician; after death. completely filled in by the funeral director, Director: After 24 hours a Hospital within 2 the

State Registrar

Examine

Prylicse Steven 31. Date filed (Month, Day, Year)

MAY 27

5 Pending investigation

Could not be determined

MO

and manner stated.

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

Res-000

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1 Tes

2 🗌 No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

600 North Wolfe St, Baltimore, MD, 21287

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			. For	State of Ma	ryland /	Departme	ent of H	lealth a	and Me	ntal Hyg	giene		
		-	State Registrar			Certifica	ate of i	Death			Reg. No	09	18834
	Physici	an	1. Decedent's Name (First, Middle, Las	et)					2 A	Date of Dea Month	th Day	Year	3. Time of Death
And the last	/Medic	al	Joan Louise Kozak  4a. Facility Name (If not institution, give	atmost and number)		4h Ci	ty Town or	r Location o	of Death	nay 2	4c. Cour	nty of Death	1 0
	Examin	er	Doctor's Communit				nham	Loodion	,, ,, ,,			e Geo	
	Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. last i	birthday) If Uni	der 1 Year	If Under	24 Hrs. 8 Min.	. Date of Birtl (Month, Day	h /, Year)	Cou	place (State or Foreign
	Director		167-30-8918	□м 2∏ F	70	Yrs.			Ма	(Month, Da) arch 9,	1939	Penn	sýlvania
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Location							10d. Inside City Limits
	a-fsh	ctor	Maryland Prince	George's	Bowie								1 XYes 2 No
	or 28	Director	10e. Street and Number			10f.	Zip Code				10g. Citizen o	of What Cou	intry?
	s 23a	eral	4917 Rocky Spring		uns in II C		0715	lienanio Ori	gin? (Speci		JSA 14 B	Race - Amer	ican Indian
10	fter de	Funeral	11. Marital Status  1 Never Married 2X Married	12. Was Decedent E Armed Forces? 1 ☐ Wes 2 ☐ N						ify Yes or No- can, etc.)	В	lack, White,	
036	hours after death with the Maryland Iural", or items 23a or 28a-f show al Examinar, ust be notified at	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 □ Yes	2 <b>_AN</b> o	Specify:			Spec	cify: V	Mite
5-0	72 ina	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16	Sa. Decedent's U (Give kind of	work done	durina mosi	t of working		16b. Kind of	Business/Ir	ndustry
121	within iene. than "	dw	Elementary/Secondary (0-12)	College (1-4or 5-		lome Mak		3)			Own Ho	ome	
d 2	al Hygi other vent, I	Be C	17. Father's Name (First, Middle, Last)			iome mane		18. Mothe	er's Name (	First, Middle,	Maiden Surn	ame)	
/lar	uld be Menta Irked Itic ev	To B	John Roginia					Fred	da L.	Komata	Z		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, once.		19a. Informant's Name/Relationship (	Type. Print)	1	9b. Mailing Addr	•						ip Code)
e, <u>r</u>	1 and Health em 27 ther t		Frank Kozak/ Husb 20a. Method of Disposition	and	20b. Place	4917 Ro	Vame of		Lane		e, MD		own, State
nor	ages ent of tr: If its y or o		1  Burial 2  Cremation 3  □ 4  Donation 5  □ Other (Specif		ceme	tery, crematory of Tohn <sup>1</sup> s C	r other plac	i .	5/30/2	2009	Conne	11svi	lle, PA
Baltimore,	mit. Partme		21. Signature of Funeral Service Licer		Jour J			-					al Home
ñ	Depar Impo any Ir		KARTY			1600	0 Ann	apoli:	s Road	d Bowi	e, MD	20715	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death. D	o not enter the r	node of dyi	ng, such as	cardiac or	respiratory ar	rrest,		Approximate Interval Between Onset and Death
4	Physician		Immediate Cause (Final disease or condition resulting in death)		dio	Phl	Mov	rary	A	Y~ 18	1		
ч	/Medical Examiner	Ш	Toodaling in accumy	Due to (or as a	consequence		1.54	, /					
	_	ĕ	Sequentially list conditions,	b. Due to (or as a			00,						20045
	ecuted nd transit	Examine	rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c. SEDI	. L		ock						213013
60,	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or ās a	a consequent	ce of):							
09289	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Medical		d		<del></del>							
Box (	eath certific attending p for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d.	Date of deli	*
	death he atte	sicia	in the past 12 months? 1 □ Yes 2 12 No	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown			ic pregnand (specify) _	-y				Month	Day Year
P.0	requires that the de wen signed by the a hould be detached is	Phy	9 ☐ Unknown  Part II. Other significant conditions		it not resultin	a in the underlyin	n cause niv	en in Part I		23e. Did to	obacco use c	ontribute to	the cause of death?
ds,	signe d be c	g p	Tarin outsi organiouni oonuniono	official and the second and the		g,	3			1 🗆 🗎	yes 2⊠No	o 3 □ Pr	obably 4 🗆 Unknown
CO	w requir s been si should I	Completed	•							24a. Was	an 24	1b. Were au	topsy findings available
Re	The law ate has b	d mo		<u> </u>						autor perfo 1 □ Yes	osy rmed? 2 100	death?	completion of cause of
ita		Be C	25. Was case referred to medical examiner?	/				26. Place	e of Death	(Check only o			
of Vital Records,	Physician: r this certific ral director, I	ို	1 ☐ Yes 2∕ ☐ No	Hospital: 1 Inpatie		Outpatient 3		4 🗆 NI		e 5 Resi			cify)
	ding F	ioi	27. Manner of Death  1. ✓ Natural 5 ☐ Pending  2 ☐ Accident investigatio	28a. Date of Injui (Month, Day	(Year)	b. Time of Injury M	28c. Inju Wor	ryat rk? ]Yes 2□		Bd. Describe I	now injury oc	currea	
Division	Attending r death. ector: After by the fune	ifica	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	e 28e Place of Inju	iry - At home	, farm, street, fac				Bf. Location (	Street and Nu	ımber or Ru	ıral Route Number,
Ö	tal or rs afte al Dire ed in I	Certification:	4   Horniciae	building, etc	;. (Specify)					City of 101	wii, Giale)		
	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer		(Check only 2 Medical Exa	nysician: To the best on the basis of	examination	dge, death occur and/or investiga	red at the t tion, in my	ime, date a opinion, dea	nd place, a ath occurre	nd due to the d at the time,	cause(s) and date and pla	d manner as ce, and due	s stated. to the cause(s)
	o the ithin 2 o the omple	Medical	29b. Signature and title of certifier	and manner sta	itea.		29c. Licens	se number	- 6		29d. Date sig	gned (Monti	h, Day, Year)
	\$ 2 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	N	DAW N	- Mel	No	M	1) 2	33[	16		5/2	LLI	09
	D'AN.	1	30. Name and address of person who	completed cause of d	eath (Item 23	la) (Type, Print)	(		Λ -	\$50	a Col	lese	Nat MA
	10/20		ARVIND M. N	NEKTA M			tim	LIVE	FILE	420	1	20	7) (-
净	Sta		31. Date filed (Month, Day, Year)		ar's Signature	4							

Registrar
DHMH 17 Rev 1/2001

Kozak Jean

State of Maryland / Department of Health and Mental Hygiene [] [] 9 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Enid Ethel Leininger May 22, Kreiser 2009 12:30 a<sup>M</sup> /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Lakeside Assisted Living at Mallard Landing Wicomico Salisbury Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 02/06/1921 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days 1 ☐ M 2**X** F Yrs. 167-14-4429 88 Pennsylvania Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "naturel", or items 23a or 28e-f show the Medical Examiner must be notified at 1 Yes 2 □ No Wicomico Maryland Salisbury Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1109 S. Schumaker Drive 21804 USA filed within 72 hours after death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: white Ď 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) management supervisor Bell Telephone 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental ! permit. Pages 1 and 2 should be Department of Health and Mental Importent: If item 27 Is marked any injury or other treumatic ev 2008. Elmer Ellsworth Leininger Margaret Sarah Bleichert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frederick Kreiser/son 315 Lillian St., Hebron, MD 21830 20b. Place of Disposition (Name of cometery, crematory or other place)
Springhill Memory
Gardens 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 5/27/09 Hebron, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service Licensee 22. Name and Address of Facility Holloway Funeral Home, Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 (Domon) CFSP Approximate tnterval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ASCUD **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. physicien Physician/Medical the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ģ in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy 2□ No 2 🗷 No 1 Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 🗌 Yes this the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Mangfer of Death 28c. tnjury at Work? 28d. Describe how injury occurred After t Certification: Hospital or Attending 5 Pending investigation 1 Naturat death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by within 24 hours after To the Funerel Direct 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 247094 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VATERN shew 1415 S. DIV 31. Date filed (Month D 32. Pigistrar's Signature State

DHMH 17 Rev 1/2001

Registra

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 12:40<sup>P M</sup> Livingston Lindsay Roslyn G. 2009 May 24, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Spring
If Under 1 Year If Under 24 Hrs. Montgomery Holy Cross Hospital 8. Date of Birth (Month, Day, July 7, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Min. 1 ☐ M 2 🖾 F Months Days Atlanta, Ga. 1926 Director 253-30-1063 82 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County "natural", or items 23a or 28a-f show often Exprine mast be rectified at ¥ Yes 2 No Director Silver Spring Maryland Montgomery permit. Pages 1 and 2 should be filed within 72 hours after death with the N Department of Health and Mental Hygiene. Important: If ten 27 is marked other than "nature." any injury or other traumation... 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 20906 United States 14216 North Gate Dr. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Specify: Black 1 ∐Yes 2√x No Specify: ģ 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Employee Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Annie Lee Russell Roosevelt Goodson ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22041 3807 Bell Manor Ct. Falls Church, Va. David Livingston / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 30,2009 Silver Spring, Maryland Gate of Heaven 22. Name and Address of Facility Pope, P.A. Alexander S. Pope, P.A. 5538 Martboro Pike 20747 21. Signature of Funeral Service Licensee 0 MOLUSS 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** RIGHT MIDDLE CEREBRAL ARTERY STROKE WEEKS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HYPERTENSION YEARS Securate by list on fines, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine or Attending Physician; The law requires that the death certificate be executed DIABETES MELLITES, TYPE 2 YEARS physician and the burial-trans resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by BREAST CANCER, TYPE B AORTIC DISSECTION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown been si should t 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ATRIAL FIBILLATION this certificate has be director, page 2 sl autopsy performed 1 ☐Yes 2 DiNo 2 540 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) 1 Yes 2 No 1 Dopatient 2 ER/Outpatient 3 DOA Certification: To this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral or 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Hospital 1994 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

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State Registrar D 0065485

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year nn ane /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Hospic Easto If Under 1 Year | If Under bot -a/60 House Year) 910 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1□ M 2□ F Months Days Hours 220-01-**Director** Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Examiner must be notified at 1 Pres 2 □ No Director as ON MD albut 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? US items 23a asant Completed by Funeral 12. Was Decedent Ever in U. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: 3 Widowed 4 ☐ Divorced lack event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Worker rood rocess n 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wilson မ 4a P Hazelton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 526 Alabama Ave. Apt. & Salisbury MD. 19a. Informant's Name/Relationship (Type, Print) Ave. Apt. E Alabama alisbury MD 21801 Important: If item any injury or other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 21. Signature of Funeral Service Licensee

22. Name and Address of Ficility

23a. Part Letter the disease, or complications that caused the deals shock, or heart failure. List only one cause on each line.

Immediate Cause (Final 1 ☑ Burial 2 ☐ Cremation 3 Removal from State Easton, MD. Cambridg e MD. 21613 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** -lectrolyte disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Securification if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence The law requires that the death certificate be executed as the burial-trai Due to (or as a consequence of): physician Physician/Medical attending IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 mopths?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy ģ Month Day Year Pregnant at time of death 5 Other (specify) o the 2 should be detached 9 Unknown 9 Unknown signed by ۵. Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 3 Probably 4 ₩ bnknown 1 🗌 Yes 2 🔲 No Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performe page 2 4NO 1 ☐ Yes or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other:  $4 \square$  Nursing Home  $5 \square$  Residence  $6 \square$  Other (Specify) Hospice 1 Tes 2 1√No 1 Inpatient 2 ER/Outpatient 3 DOA After this Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director: the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and addre

State Registrar 31 Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Latham Beverly OC /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Wicomico Coastal Hospice @ the Lake Salisbury If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Hours Min. Days 1 □ M 2 🛛 F Months 025-32-9938 **Director** 1-22-1943 66 Massachusetts Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ir than "natural", or items 23a or 28a-f sho Director 1K∏Yes 2∏No MD Wicomico Pittsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21850 USA 34818 Old Ocean City Road Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2**∑** No 1 □Yes 2X No Specify: White Specify. \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Own Home 12 Homemaker 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be and Mental ၉ Walter I. Longmuir Helen Wilman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21850 D'Arcy Latham, Jr. - Husband 34818 Old Ocean City Rd., Pittsville, Maryland other Department of Heal Important: If Item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages ' 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-26-2009 Delmar, Delaware Crematory of Delmarva 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bounds Funeral Home Misa 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 5 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): physician Physician/Medical the as attending IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) detached 9 ☐ Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably ↓ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 1 □ Yes funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To MOSNICE this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 24 hours after deatle Funeral Director: filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b Signatu a Name and address of person who completed cause of death (Item 23a) (Type, Print) Bergmuelle MD MUM

State Registrar

21215-0036

Maryland

Baltimore,

P.O. Box 68760.

Records,

Division of Vital

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 5:40P Monroe C. Leonard 2009 MAY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Berlin Nursing & Rehabilitation Ctr Worcester Berlin If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6 Sex **Funeral** Hours Months Days Min. 1 🕱 M 2 🗆 F 220-28-2561 April 26,1931 MD Director 78 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show ortant; if item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the "Medical Evant had reast be mailthed at 1√2Yes 2 □ No Director MD Worcester Whalevville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11805 Sheppard Crossing Road 21872 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ➡ No Specify Specify: Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than" any Injury or other traumatic event, the Magnetic event events are supplied to the Magnetic events and the Magnetic events are supplied to the Magnetic events and the Magnetic events are supplied to the Magnetic events and the Magnetic events are supplied to the Magnetic events and the Magnetic events are supplied to the Magnetic events and the Magnetic events are supplied to the Magnetic events and the Magnetic events are supplied to the Magnetic events and the Magnetic events are supplied to the Magnetic events and the Magnetic events are supplied to the Magnetic events and the Magnetic events are supplied to the Magnetic events and the Magnetic events are supplied to the Magnetic events and the Magnetic events are supplied to the Magnetic events and the Magnetic events are supplied to the Magnetic events and the Magnetic events are supplied to the Magnetic events and the Magnetic events are supplied to the Magnetic events and the Magnetic events are supplied to the Magnetic events and the Magnetic events are supplied to the Magnetic events and the Magnetic events are supplied to the Magnetic events are supplied to the Magnetic events and the Magnetic events are supplied to the Magnetic events and the Magnetic events are supplied to the Magnetic events and the Magnetic events are supplied to the Magnetic events and the Magnetic events are supplied to the Magnetic events and the Magnetic events are supplied to the Magnetic events and the Magnetic events are supplied to the Magnetic events and the Magnetic events are supplied to the Magnetic events and the Magnetic events are supplied to the Magnetic events are supplied to the Magnetic events and t Elementary/Secondary (0-12) College (1-4or 5+) Self Employed 8th Handyman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carvey Leonard Gertrude Showell ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Thomas Leonard/brother 10615 Flower St., Berlin, MD 21811 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Pulletts UMC Cemetery May 20,2009 Whaleyville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lewis N. Watson Funeral Home, PA 21. Signature of Funeral Service Licensee 1618 West Rd., Salisbury, MD 21801 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the I within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie ASTERN SHORE State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records,

LEONARD, MONROE

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	1- For State Certificate of Death Reg. No.									
Physici	an/	Decedent's Name (First, Middle,Last)			Date of Death     Month Da	y Year	3. Time of Death			
Medical Exami	ner	Kenee Mees	e		June 4, 2009		0622 hrs			
		4a. Facility Name (if not institution, give street and number		4b. City, Town, or Location of Death		4c. County of Death				
		Western Maryland Health System Braddo	ock Campus	Cumberland		Allegany				
Funeral		5. Social Security Number 6. Sex 7. A	ge (In yrs. last birthday)		8. Date of Birth (N		thplace (State or Foreign untry)			
Director		220-80-7925 1_M 2XF	4/0 Yrs	Months Days Hours Min.	(19/28/	1962 m	30 1/000			
		Usual Residence of Decedent			10 17.00 91	even III	gois			
any		10a. State 10b. County	10c. City, Town or Locat	tion			10d. Inside City Limits			
* *		Mounted Allows	1 mm	1100			1 Yes 2 No			
rylan	용	10e. Street and Number	MINIM	10f Zip Code	10a.	Citizen of What Cour	ntry?			
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ath w	Funeral	1 Never Married 2 Married Armed Forces		If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.						
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5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	by	or Dates:  15. Decedent's Education (Specify only highest grade co	moleted) 16a Deceder	nt's Usual Occupation (Give kind of v	ork done	b. Kind of Business/I	Industry			
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d with	5	17. Father's Name (First, Middle, Last)	den Surname)	//						
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	To E	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State								
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e, MC I and 2 sl Health ar item 27		20a. Method of Disposition	20b. Place of Dispos	sition (Name of cemetery.	Date 20	Oc. Location City or				
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altimore mit. Pages 1 a partment of Hi pportant: If it ury or other t		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		OCCOMO SOLVEN		unharby	Mayera			
Baltim permit. Pag Department Important:		Backer of the land				MULLET CO	21839			
Physician		23a. Part I. Enter the disease, or complications that cause			r respiratory artes.	shock, or heart	Approximate Interval			
/Medical	- 24	failure. List only one cause on each line.					Between Onset and Death			
kaminer		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a constitution of the condition resulting in death)	stive heart	Tallure			1			
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3760, ficate be ex g physician s the burial	edi					23d. Date of deliver				
- 4 00 to	2	23b. Was decedent pregnant in the	me of pregnancy	etal death 3 Ectopic pregna	incy		y Day Year			
Box 68 e death certi the attending	icia	past 12 months?	t time of death	ther (Specify)						
Box 687 ne death certific the attending perfection and the control of the control	Physiciar	1 Yes 2 No 9 V Unknown g Unknown								
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rds requ	Completed	disease			24a. Was an autopsy		utopsy findings available completion of cause of			
eco ne law te has ge 2 s	틹				performe 1 ✓ Yes 2	ed? death?				
tal Rectian: The certificate ector, page		25. Was case referred to medical		26.Place of Death (Check			2 110			
Vital F hysician: this certifi	Be	examiner?	ent 2 V ER/Outpatien	Othory		sidence 6 Othe	r:			
Division of Vital Records, P.O. Box 68 tall or Attending Physician: The law requires that the death certins after death.  al Director: After this certificate has been signed by the attendin led in by the funeral director, page 2 should be detached for use as	1	1 ✓ Yes 2 No 1 Inpati 27. Manner of Death 28a. Date of In (Month, Day)			28d. Describe how					
ion (tending eath.	힐	1 X Natural 5 Pending (Month, Day,	Year)	1 Yes 2 No						
	g	2 Accident Investigation 28e, Place of I	niury - At home, farm, stre	et, factory, office building, etc.	28f. Location (Stre	et and Number or R	ural Route Number, City			
Divis pital or At ours after d eral Direc	ertification:	Suicide 6 Could not be determined (Specify)			or Town, State	)				
E G G	ပြ	29a. Certifier	ny knowledge, death occu	irred at the time, date and place, and	due to the cause/s	) and manner as sta	ted.			
To the Hos within 24 h To the Fur completely	ledical	one) 2 Medical Examiner: On the basis of examiner								
To COT	ě	29b. Signature and title of certifier		29c. License number	2	9d. Date signed (Mo	onth, Day, Year)			
		11/1 /1 /1/ MA	_	O.C.M.E.	J	lune 5, 2009				
		30. Name and address of person who completed cause of	death (Item 23a)							
OCME		Melissa Brassell, MD Assistant Medica		Penn Street, Baltimore, MD	21201					
21	ate		ar's Signature							
Regis	rar	31. Date filed Moran, Pay Year 32. Registr	S. park	,						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death Day Physician 06/05/2009 ANNA L. MILLS /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** CHESAPEAKE WOODS CENTER DORCHESTER CAMBRIDGE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 🔀 F Yrs. **Director** 91 10/27/1917 214-07-7964 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show the Medical Examiner must be notified at Directo MARYLAND DORCHESTER **CAMBRIDGE** 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or Items 23a or 2: any injury or other traumatic event, the Medical Exercises or 2: any notes. 10e. Street and Number 10f. Zip Code 424 LECOMPTE ST. 21613 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 No Specify: à Specify. 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LICENSED PRACTICAL NURSE **HEALTHCARE** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ RICHARD SAMUEL TODD IDA DELIVA BRAMBLE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STEVE MILLS, SR. / GRANDSON 4810 LAURIE LANE, WOOLFORD, MD 21677 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/8/2009 CAMBRIDGE, MD DORCHESTER MEMORIAL PARK 22. Name and Address of Facility 21. Signature of Funeral Service Licensee CURRAN-BROMWELL FUNERAL HOME, P.A., 308 HIGH ST. CAMBRIDGE, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Dus to for as a consequence off Due to (or as a consequence of): Box 68760, Physician/Medical yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ZHVo 4 Pregnant at time of death Month 5 ☐ Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 🗌 No 3 Probably 4 ☐ Unknown 1 Tes Completed 24a. Was an autopsy performed? ↑ □Yes 2 ☑No 24b. Were autopsy findings available prior to completion of cause of death? a 1 TYes Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 1√10 Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28a. Date of Injury (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

4:00 A

MARYLAND

WHITE

Approximate Interval Between Onset and Death

Day

2 400

28d. Describe how injury occurred

several years

Year

10d. Inside City Limits

1XYes 2 No

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, ours after death.

leral Director: A
filled in by the fi within 24 hours a To the Funeral D

1 ■Natural 2 □ Accident	5 Pending investigation	(Month, Day, Year)	(Month, Day, Year) Injury Work?  M 1 □ Yes 2 □ No							
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At hon building, etc. (Specify)	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number City or Town, State)				
9a. Certifier (Check only one)	1 Certifying Phys 2 Medical Examin	I lcian: To the best of my know er: On the basis of examinati and manner stated.	rledge, death occurre on and/or investigation	d at the time, date on, in my opinion, o	and place, and death occurred a	due to the cause( at the time, date ar	(s) and manner as state nd place, and due to the	d. cause(s)		
9b. Signature and	Ditle of certifier	- D.O.	29	Oc. License number	4615	29d. D.	ate signed (Month, Day	Year)		
). Name and add	ress of person who cor	npleted cause of death (Item	23a) (Type, Print)	B(A	uble	5+	Canbo	ids 4		

28c. Injury at Work?

28b. Time of

State Registrar

27. Manner of Death

31. Date filed (Month, Day, Year)

2 Medical 2

30

State of Maryland / Department of Health and Mental Hygiene 1 - State RegistrameND#20coerrFH, 6/5/09, EMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** May 24, 2009 8:30 a M Maurice E. Meyer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Silver Spring Montgomery Holy Cross Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, 01/11/1916 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months New York 1 1 M 2 □ F 93 065-09-0469 Director Usual Residence of Decedent 10d. Inside City Limits the Marylan 10a. State 10b. County 10c. City, Town or Location Rockville 7 is marked other than "natural", or items 23a or 28a-f sk traumatic event, the Mudical Examiner must be notified Maryland Montgomery 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 20853 15908 Maple Ridge Court USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: white ģ Widowed 4 ☐ Divarced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Person Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Israel Meyer Ethel Knopf ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara E. Weintraub-daughter 4301 Prince Road, Rockville, Maryland 20c. Location - City or Town, State
Two of Washington
Paramus, New Jersey 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Pages 1 nent of F ant: If ite 1 ☑ Burial 2 ☐ Cremation 3 ☑Removal from State Department I I Important: If any Injury or once. Beth El Cemetery 05/28/2009 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee EDWARD SAGEL FUNERAL DIRECTION, INC. MO1255 1091 Rockville Pike, Rockville, Maryland 23a. Part Finter the dise in , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** days Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner days Pneumonia Sequentially list conditions, if any, leading to immediate Files or injury Examiner Due to (or as a consequence of) death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 C Ectopic pregnancy Month Year Day 5 Other (specify) signed by the a 1 □Yes 2X□No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Urinary Tract Infection 1 Yes 2 No 3 Probably 4 Unknown Completed need 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 □ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☒ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 2 XNo this 2 ER/Outpatient 3 DOA Certification: To funeral within 24 hours after death.

To the Funeral Director: After it completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifler 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D32332 May 25, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suresh K. Gupta, MD, 9801 Georgia Avenue, Suite 220, Silver Spring, MD 20902 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 10:10FM Nancy Ann Miller MAY 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Saint Joseph Medical Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Funeral Months Days Min. Hours 1 □ M 2 🔯 F **Director** 215-34-3780 Oct. 13,1940 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits if than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 ☐ No Director Maryland Washington County Boonsboro 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 19625 Shephendstown Pike 21713 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ∐Yes 2 ∏ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, Its Magnee. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Personal Residence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ James Howard Patterson, Sr. Betty Lee Mason Patterson Gosma 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chester W. Miller-husband 19625 Shepherdstown Pike Boonsboro, MD 21713 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. View Cemetery 4 Donation 5 DOther (Specify) 6-1-2009 Sharpsburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SEPSIS /Medical Due to (or as a consequence of): Examiner PERITONITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): P.O. Box 68760, aftending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the afte in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Hunknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>≽</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown been si should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 □Yes 1 □Yes e Hospital or Attending Physician: 24 hours after death.
Funeral Director; After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No မ 1 ☐ Yes npatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 27. Manner of Death 1 A Natural 28a. Date of Injury (Month, Day, Year) Certification: 28b. Time of 28d. Describe how injury occurred Injury at Work? 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) To the within 2

-3H-5

State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

D46353

DRIVE TOWSON, MARYLAND

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 5 8:30 P Claire L. Michelotti 26 2009 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 11431 Manklin Creek Rd. Ocean Pines Worcester 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8/31/1924 Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) Months Days Hours 1 □ M 2 🔽 F CT 102-16-2933 84 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Worcester Ocean Pines 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11431 Manklin Creek Rd. 21811 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 ☐No Specify: Specify: white 3 □ Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 9th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frank Lane Josephine Nichols 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynne Swift / daughter 14 Carriage Lane, Ocean Pines, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ XCremation 3 ☐ Removal from State 5/27/2009 Cape Henlopen Crem. Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Pard . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Comany party Ps Due to (or as e consequence of): chronic ob shutive Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Conjustive Heart failur Due to (or as a consequence of) 5teres is 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes → No 3 ☐ Probably 4 ☐ Unknown erythana tegis 24b. Were autopsy findings available prior to completion of cause of death? Hyper Jewin 24a. Was an autopsy performed? A-Ab 1 ☐ Yes 2 ☐ Mo 26. Place of Death (Check only one)

**Physician** /Medical Examiner

attending physician and for use as the burial-transit

this certificate has been signed by the al director, page 2 should be detached

funeral director.

After t

To the Hospital or Attending Pl within 24 hours after death, To the Funeral Director: After th completely filled in by the funeral

Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other trai once.

**Physician** 

/Medical

Examiner

10a. State

MD

Director

Funeral

þ

Completed

Be

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show usy or other than the Nortical Examiner must be notified at ury or other traumatic event, the Martical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physician/Medical þ Completed Be Certification: To

Medical

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

Systemic Lupers

25. Was case referred to medical 1 Yes 2 1 No 27. Manner of Death

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) investigation

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 🔛 Natural

3 ☐ Suicide

2 Accident

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier R

5 Pending

6 Could not be determined

29c. License number 40066462

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) 5-27-09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jeffrey Scheirer, 10514 Racetrack Rd., Unit C, Berlin, MD 21811 31. Date filed (Month, Day, Year) 32.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

MAY 28 2009



BA 4

1 ☐ Yes

28f. Location (Street and Number or Rural Route Number, City or Town, State)

May 28, 2009

29d. Date signed (Month, Day, Year)

1 ☐ Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify) living

28d. Describe how injury occurred

26. Place of Death (Check only one)

2 No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** May 28, 2009 Jacob Russell Morrison 9:20 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shangri-La Assisted Living Ellicott City Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**X** M 2 □ F 210-07-7875 12, Director 1914 Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, Inc. "colors Evanings must be notified at 1 ☐ Yes 2 No Funeral Director MD Howard Ellicott City 10e. Street and Number 10g. Citizen of What Country? 4475 Montgomery Road 21043 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Was Decedent 1 of the last of Black, White, etc. 1 ☐ Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 📉 No Specify: White Be Completed by 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Health and Mental Jacob Samuel Morrison Hallie P. Sullivan ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry E. Ruygrok/daughter 4090 Old Columbia Pike Ellicott City, MD 21043 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 05/29/09 W. Arundel Crematory Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 23a. Part 1. Enter the disk se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MO125 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death Immediate Cause (Final Diabetes Mellitus, Type II **Physician** years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 \subseteq Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Coronary Artery Disease, Hypertension 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Osteoporosis autopsy performed? Yes 2 X No

P.0. Division of Vital Records,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and

Certification: To

25. Was case referred to medical examiner?

5 ☐ Pending investigation

6 Could not be determined

1 ☐ Yes 2 ☐**X**No

27. Manner of Death

1X Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only

29b. Signature and title of certifier

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harry Li, M.D. 8600 Snowden River Parkway #301 Columbia, MD 21045

32. Registrar's Signature parkel

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

M.D.

28b. Time of Injury

28c. Injury at Work?

29c. License number

D56531

1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

28a. Date of Injury (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

			State of Maryland / Department of H  State of Maryland / Department of H  Certificate of L			ene 1. N2. 0 0 9	18846
			1. Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year	3. Time of Death
	Physicia /Medic		Helga Maria Miles		May 25	2009	12:50 AM
	Examin	er		r Location of Death		4c. County of Death	101
			Crofton Care and Rehab. Center Crofton  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year		8 Date of Birth	Anne Aruno	place (State or Foreign
	Funeral Director		381-34-3123 1 M 2 F 82 Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day, ) 12/6/192	(ear) Cou	ntry)
	ס		Usual Residence of Decedent				101 1-11-01-11-11-
	arylar show	7	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits 1 ☐ Yes 2 A No
	the M	ectc	MD Anne Arundel Odenton  10e. Street and Number 10f. Zip Code		100	g. Citizen of What Cou	
	with sa or i	i Dir	695 Winding Stream Way #202	21113		USA	·
	death	era	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hi		1	14. Race · Ameri	can Indian,
ဖွ	efter or ite	by Funeral Director	Armed Forces? If Yes, specify Cuba  1 □ Never Married 2 □ Married   I □ Yes, 2 △ No   If Yes, Give   1 □ Yes, 2 △ No	Specify:	nican, etc.)	Specify: 5.7%	
003	hours ural',	d b	3 ☐ Widowed 4XD Divorced Year or Dates:			WIII	
7	in 72 i	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done of life, DO NOT use retired	durina most of workii		8b. Kind of Business/Ir Sept. of Ar	
212	filed within 72 hours efter death with the Maryland Hygiene. ther then "natural", or items 23a or 28e-f show ent, the Mudical Exammer from the Lon Milled at	omo	Elementary/Secondary (0-12) College (1-4or 5+)  12 Staffing Spec	cialist	Ţ	J.S. Govern	ment
pu	e file al Hyg I othe	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name			
<u>ya</u>	ould b Ment arkec	To I	Walter Lazer	Johanna		deBoom	
Maryland 21215-0036	12 sh h end 7 ls m treum		19a. Informant's Name/Relationship (Type, Print)  Linda Blanton / daughter  2016 Howard				21114
ē,	1 and Healt tem 2		20a. Method of Disposition 20b. Place of Disposition (Name of	. D		Oc. Location - City or T	
ē	Pages ent of nt: If i		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  Cemetery, crematory or other place Bayview Crematory		2009 B	altimore,	MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Depertment of Health end Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23a or 28e-f show any injury or other treumatic event, the Medical Examinating medical and once.		21. Signature of Fundral Service Licensee 22. Name and Address			eral Home	
<u>m</u>	8858		6512 NW (	Crain Hwy.	. Bowie,	MD 20715	,
ı			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dyin shock, or heart failure. List dispone cause on each line.		r respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)  a. Caediac Tmyltmu	a			
ř.	/Medical Examiner		Due to (or as a consequence of):				
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				
	cate be executed physicien and the burial-transit	dicai Examiner	that initiated events c.				
Ö,	ate be executed hysicien and the burial-transit	EX	resulting in death) Last Due to (or as a consequence of):				
8760,	cate b	dica	d				
9 X	feeth certifica attending pl	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	-		23d. Date of deliv	verv
Box	deeth certific e attending p od for use as	Physician/Me	in the past 12 months?  1 Ves 2 NNo.  1 Petal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)	'		Month	Day Year
P.O.	that the deeth	hys	9 ☐ Unknown			1	
Ś	8 50	by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	en in Part I.		acco use contribute to	
ord	w require	eted	failure to larce			3 2 No 3 Pro	X
3ec	has t	Completed by			24a. Was an autopsy perform	ed? prior to c	opsy findings available ompletion of cause of
<u>a</u>	in: Th	e Co	25. Was case referred to medical	26. Place of Death	1 ☐ Yes 2	No 1□Yes	2 No
$\equiv$	Physician: r this certific ral director,	To B	examiner?  1 Yes 2/1 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other	or (2031)		nce 6 Other (Spec	ify)
0	ng Ph ter th		27. Manner of D ath 1 ★Natural 5 Pending 28a. Date of Injury 28b. Time of Injury World 1 World 1 Status 1 Status 28c. Injury World 28c. Injury World 28c. Injury		28d. Describe hov	v injury occurred	
Siol	Attending or death. ector: After by the fune	catic	2 Accident investigation M 1	Yes 2 □ No			
Division of Vital Record	of or Attend efter death Director: /	Certification;	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Stre City or Town,	eet and Number or Ru State)	ai Houte Number,
_	To the Hospitel or Attending Physician: The i within 24 hours efter death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time	ne, date and place.	and due to the car	use(s) and manner as	stated.
	n 24 h	edicai	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my or and manner stated.	pinion, death occurr	ed at the time, da	te and place, and due	to the cause(s)
2 3	To the To the complet	M	29b. Signature and the of certifier 29c. Licenso		29	d. Date signed (Month	
•	0201	7	D	57028		05-24-	09
	do		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	nue # 23	Anna	ONL + MAC	21401
	Sta	te	CALLED TO THE COLUMN TO THE CO	) UC 11 C3	1-1111111111111111111111111111111111111	Torred 1-00	- 1-101
	Registr		MAY 27 2009 Kenne S. Jack				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Robert Lee Mitchell May 22, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Wicomico 31425 Johnson Road Salisbury 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1XXM 2 □ F Months Days Hours Min. Director 214-28-3765 86 July 18, 1922 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it woulds! Exactions in the motified at Director 1 ☐ Yes 2 No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 31425 Johnson Road 21804 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2XX Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2XXNo þ Specify. Specify: 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Farmer Truck Crops is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be William Mitchell Mary Pryor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trau Salisbury, MD Frances S. Mitchell (Wife) 31425 Johnson Road 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mitchell Cemetery May 26, 2009 Salisbury, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility
Short Funeral Home 3 East Grove Street Delmar, DE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or learn ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 45CVI) ) /Medical Due to (or as a consequence of) Examiner CVA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) The law requires that the death certificate be executed as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Por Month Day Year 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 autopsy certificate 2 □No 2 PNo 1 ☐ Yes 1 □ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 ☑ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation s after death. 1 □Yes 2 □ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 047094 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAZISBURY 5 DIVISION Sheel 1415 Vel 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

09-04439 **Duane Morris** 

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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			I- For State Certificate of Death Reg. No.														
	Physicia		Registrar  2. Date of Death Month Day Year  1. Decedent's Name (First, Middle,Last)  3.								3. Time of Death 2112 hrs						
	Examir		DUANE ROBERT MORRIS								P 1	Darth	June 3, 2		1c. County of	Death	
			4a. Facility Name (if not institution, give street and number) 11854 Highview Circle						4b. City, Town, or Location of Death Lusby						4c. County of Death  Calvert		
		4				. Sex 7. Age (In yrs. last birthday)			If Under 1 Year If Under 24Hrs			24Hrs	8. Date of Birth(M		W/DD/YYYY)	9. Bir	thplace (State or
	Funeral		5. Social Security N 215-19		6. Sex		3.5		Months	Days	Hours	Min.			973	Carata	untry) WASH.D
	Director				1 XM 2	F		Yrs				1					
8	any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Ins								10d. Inside City Limit						
4	<b>*</b>		MD.	CAI				LU	SBY						1 Yes 2 X N		
1	Maryland 28a-f show d at once.	핡	10e. Street and Number					10f. Zip Code					10g. Citizen of What Country				ntry?
	th the Maryland 23a or 28a-f sho notified at once	Director	11854 HIGHVIEW CIRCLE				20657					U.S.A.					
	ith th		11. Marital Status 12. Was Decedent Ever in U.S					13 Was Decedent of Hispanic Origin? ( S					pecify Yes or No- 14.				rican Indian, Black,
	ath w items ust be	Funeral	1 XNever Married 2 Married Armed Forces? 1 Yes 2X No					If Yes, specify Cuban, Mexican, Puerto				Puerto I					
	fter de		3 Widowed 4 Divorced If Yes, Give Year					Yes 2		_					WHITE		
	led within 72 hours after tygiene. other than "natural", the Medical Examiner	d b	15. Decedent's Education (Specify only highest grade completed)				6a. Deceder	nt's Usual C	ccupatio	on (Give k	ind of w	ork done ed)	16b	. Kind of Bu	siness	/Industry	
"	72 hc n "na sal Ex	Completed	Elementary/Sec	ondary (0-12)	Colle	College (1-4 or 5+)			during most of working life. DO NOT use reti GROCERY MANAGER						SIANT	F	OODS
03	vithin 72 ene. er than Medical	ğ	1 2 17. Father's Name (First, Middle, Last)								ne (First, Middle, Maiden Surname			)			
5-0	Hygi d oth	_				C				- 1"						,	
21215-0036	uld be filed wit Mental Hygien marked other c event, the M	Be		DONALD K . MORRIS  19a. Informant's Name/Relationship (Type, Print)				19b. Mailin	g Address	(Street			SE BRATCHER  r Rural Route Number, City or Town, State, Zip Code)				te, Zip Code)
MD 2	2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once must be notified at once	2	DENISE						I GAI						E PLA		
_	es I and 2 shoul of Health and M If item 27 is m ther traumatic	24.1	20a. Method of Di	sposition			20b. Pla	ace of Dispo ematory or o	sition (Nam				Date	20	c. Location	- City o	or Town, State
Baltimore,	permit. Pages I and 2 Department of Health Important: If item 2 injury or other traur		1 X Burial 2			val from S	HER HER	ITAGE	E MEM	I.GA	RDE	N 6	-9-09	V	VALDO	RF	, MD.
Itim	permit. Pages I Department of F Important: If i	1	4 Donation 5	5 Other S	pe <i>cify:</i> Licensee	M004	79	22.	Name and	Address	of Facility				7E D	7	
Ba	Departing in jun	133	mi	lun		171.11			RAYMO LA PI	JAD ATA	FUNI MAI	ERA. RYL.	L SER	067	CE,P.	A •	
ات	hysician	7. 1	3a. Part I. Enter	the disease, or	complic nor	that cause	d the death. [	Do not unter	the mode o	f dying,	such as c	ardiac o	r respiratory	arrest,	shock, or he	art	Approximate Inter- Between Onset a
	Medical		Immediate Cause		a. Sud	den u	inexpla	ained	deat <u>h</u>	in	epi1	eps	У				Death
_	xaminer		or condition resul	ting in death)	Due to (d	r as a con	sequence of):										
		-	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):														
	d sit	nine	Cuses or injury that initiated c.														
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o.	s be ex siciar burial	S UNPENDED AMENDED									ery						
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× 68	h cert tendir r use a	icia	past 12 mont		4	Pregnant	at time of dea	1th 5 (	Other (Spe	cify)				_			
Box	he death certific the attending hed for use as the	Physician	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of de								to the cause of death?						
0	ires that the signed by t	by P	Part II. Other sig	nificant cond	itions contrib	uting to de	ath but not re	sulling in the	unuenying	Cause	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	u					robably 4 🗸 Unknow
	uires m sigr Id be	l pa											24a. V	Vas an	24b.	Were	autopsy findings availa
ord	law requi	를	·								<del></del>		r	utopsy erform		death	
of Vital Records.	The la	Completed	1									101		es 2	No	1 🗸	Yes 2 No
7	ysician: The his certificate director, page	Be	25. Was case ref examiner?	erred to medic	al Hospital:					26.Place	Other		ng Home 5	Re	esidence 6	<b>√</b> 0	ther: Scene
Š	Physic r this	ို	1 ✓ Yes 27. Manner of De	2 No		1 Inpa		ER/Outpatie			ry at Wor				w injury occu		
	ding Phy. h. After tl	i.e	1 X Natural		nding	(Month, Da	y,Year)		, ,	1	Yes 2	No	ì				
	Attend r death ector: by the	cati	2 Accident	lnv	estigation 28	e. Place of	f Injury - At ho	me, farm, st	reet, factory	, office I	ouilding, e	etc.				ber or	Rural Route Number,
Division	ospital or Att hours after de meral Direct	Certification:	3 Suicide	de	ula not be	pecify)							or To	wn, Sta	te)		
	file ou		4 Homicide	Contifuing	Physician: To	the best of	f my knowledg	ge, death occ	curred at the	e time, d	ate and p	lace, ar	d due to the	cause(	(s) and mann	er as :	stated.
	To the Hos within 24 h To the Fun completely	Medical	(Check only one) 2		aminer:On the	basis of e	xamination a	nd/or investi	gation, in m	y opinio	n, death o	ccurred	and due to the cause(s) and manned at the time, date and place, and			aue t	o the cause(s)
	To To	Š	29b. Signature a	nd title of certi		anner state	50,		29		se numbe	r					(Month, Day,Year)
	7.		Ü	Sd.sm						O.C.	M.E.				June 4, 2	:009	
		30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201															
			Ana Rubi		ssistant Me					Baltim ——	ore, ML	212 ر	J1				
		State		onth, Day, Yea	r)	32 Regis	strar's Signatu	are As	and of								
	Regi		Щ,	JUN-I ()	2009	CHAR	a p	ORIGIN	IAI								
DHM	/IH 17 Rev 1	/2001						OKIGIN	IAL .						00115		

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2009 Year **Physician** Charles Robert North 27 8:04 a.M May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Dorchester 113 Linthicum Drive Cambridge If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours **№** M 2□ F 1925 Maryland June 18, Director 218-16-5488 83 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f shov Examiner must be notified at MD Dorchester 1 Yes 2 No Cambridge Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 113 Linthicum Drive 21613 USA items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 132 Yes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married "natural", or Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) owner/operator service station 12 should be filed w h and Mental Hygieu is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Spedden North Marian Bromwell ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important: If item 27 is any injury or other trau Phyllis North 113 Linthicum Drive, Cambridge, MD wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State East New Market Cem. 5/30/09 4 □ Donation 5 □ Other (Specify) East New Market, MD 21. Signatura of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine burial-transit resulting in death) Last Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 9□Unknown 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2☐No 3☐ Probably 4☐Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy Be Certification: To

I or Attending Physician: The law requires that the death certificate be executed after death. Division or Vital Records, P.O. funeral director, neral Director; / within 24 hours at To the Funeral C Hospital

						1 Yes 2 100	1 ☐ Yes 2 ☐ No			
25. Was case referred examiner? 1 ☐ Yes 2 No		Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatient	3 🗆 1	eath (Check only one)  Home 5 Hesidence 6 □Other (Specify)					
27. Manne Death  1 Latural  2 Accident	Pending investigation	28a. Date of Injury (Month, Day Yo	ear) 28b. Time of Injury	M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred				
3 ☐ Suicide 4 ☐ Homicide	Could not be determined	28e. Place of injury building, etc. (3	- At home, farm, stree Specify)	et, fact	ory, office	28f. Location (Street and Number City or Town, State)	Number or Rural Route Number,			
00- 0 15	Tortifying Phy	veicing. To the heet of r	ov knowledge death	occurr	ed at the time, date and place	e and due to the cause(s) a	and manner as stated			

(Check only 29b. Signature and title of certifie

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

21613

person who completed cause of death (Item 23a) (Type, Print)

300 M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year)

and manner stated.

State Registrar

Medical

DHMH 17 Rev 1/2001

To the

	Amend PGH E	#20 LM	)a/b/c per Cem. 6/2	Type or Print in 09 State of Maryla	nd / Depa	artment of H	Health ar	e All Copies nd Mental Hy	Are Le	gible.	19850				
			Registrar Ameno# s4a.4b.		Cei	rtificate of	Death	2. Date of De	Reg. No.	000	3. Time of Death				
	Physici		Decedent's Name (First, Middle, Last,  JAMES CEC.		SR			Month MA		Year 7	10:17 M				
	/Medio		4a. Facility Name (If not institution, give			4b. City, Town, o	E Hya	ttsville	4c. Coo	unty of Death	-				
	Funeral Director		5. Social Security Number 577-56-6787  Usual Residence of Decedent	7. Age ( <i>lin yrs</i> M 2□ F  67	. last birthday) Yrs.	Months Days Hours Min.			th ay, <i>Year)</i> 1941	9. Birthplace (State or Formar) Country) WASHINGTON, I					
	Maryland a-f show	ctor	10a. State 10b. County 10c. City, Town or Location								0d. Inside City Limits 1 X Yes 2 □ No				
	or 28	Funeral Director	10e. Street and Number	10f. Zip Code					10g. Citizen	of What Cour	ntry?				
	s 23a	eral	3514 54th AVENUE		20784		o2 (Cassifu Van ar No	U.S		can Indian					
920	urs after de al'', or item	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 M No If Yes, Give Year or Dates:		<ol> <li>Was Decedent of Hispanic Origin? (stryes, specify Cuban, Mexican, Puer</li> <li>1 □ Yes 2 ☒ No Specify:</li> </ol>				14. Race - American Indian, Black, White, etc.  Specify: BLACK					
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Modical Evs. in art. was be rediffed at	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 8th	cation e completed) College (1-4or 5+)	i (Give	dent's Usual Occup kind of work done DO NOT use retired	during most o	f working		D. Kind of Business/Industry  PRTVATE					
Maryland 2	be od o	To Be Co	17. Father's Name (First, Middle, Last) UNKNOWN			OCCIT		Name (First, Middle NEWMAN							
nar)	2 sho and l is ma rauma	ľ	19a. Informant's Name/Relationship (Ty			-		or Rural Route Numb							
	l and Healt		JAMES NEWMAN JR. /	20h	Place of Diena	eition (Name of		EANSIDE, C		ion - City or To					
nor	ages ent of nt: If It		1 Dorial 2 Tremation 3 ☐ F	Removal from State Ri	cemetery, crei	matory or other place Cremato EMORIAL	ry 6	/1/09 -30-2009		•	20737				
Baltimore,	20a. Method of Disposition  20a. Method of Disposition  20a. Method of Disposition  3 Removal from State  4 Donation  5 Other (Specify)  21. Signature of Funeral Service Ligensee  22b. Place of Disposition (Name of cemetery crematory or other place)  RIVETCALE Crematory  6/1/09  12. Name and Address of Facility JB JENKIN  7474 LANDOVER RD LANDOVER							IS FUNERAL HOME R, MD 20785							
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ications that caused the deane cause on each line.  a. Atherism are but to for as a conse	notice	er the mode of dyli	ng, such as ca	ardiac or respiratory a	Dis e	51 E	Approximate Interval Between Onset and Death				
	executed in and lal-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b.  Due to (or as a consequence of):												
68760,	o ⊂ <u>a</u>		resulting in death Last	_ d											
O. Box	The law requires that the death certificate be ate has been signed by the attending physicia agge 2 should be detached for use as the bur	Physician/Medical	ysician/Me	ysician/Me	ysician/Me	ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								ery Day Year
rds, P.	juires that n signed b ild be deta	ğ	Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.								he cause of death?				
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	e Hospital 24 hours a e Funeral I letely filled	ledical		sician: To the best of my kr ner: On the basis of examir and manner stated.											
	To the within To the compl	Me	29b. Signature and title of certifier	11 + -		29c. Licens	se number		29d. Date s	igned (Month,	**				
			Jarado /	yesty De	) 	1500	557	27	MAJ	27, 2	2009				
)	5		30. Name and address of person who	mpleted cause of death (Ite	em 23a) (Type,	Print)	المحمد زم	Cho.ve	- le	MAN	2009 land				
Í	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	100	, , ,		7/						

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year **Physician** : 40 PM Lamont 2009 05 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Arundel Medical Center Polis tnna Anne Arundel 4nne If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) Mayland Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Months Days Hours 1 ₩M 2 🗆 F N/A Yrs **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits show d other than "natural", or Items 23a or 28a-f show event, the Madical Examiner must be notified at **Funeral Director** 1. Yes 2 □ No Severn 1d Hnne trunde 10f. Zip Code 10g. Citizen of What Country' 10e. Street and Number 21144 USA 606 arview Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Wever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ o Specify þ 13 Jack 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Health and Mental permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic ev Offer erron -amon't Monique ဥ anae 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) C+, Severn, Md 21144 Offer Briarview Terron 606 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 5/27/2009 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD Atlantic Crematory 22. Name and Address of Facility 21. Signature of Euneral Service License Hardesty Funeral Home, P.A. Date Annapolis, MD 21401 12 Ridgely Ave. Part 1. Enter the frease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** down disease or condition resulting in death) /Medical Due to or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been sinned by the Advance. use as the burial-trans Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No should be detached 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ► 30 24a. Was an autopsy performed 2 ☐ No 1 X Yes within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: cal Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 No 2 Accident

Box 68760, P.O. I of Vital Records, Division

> State Registrar

6 ☐ Could not be

determined

3 Suicide

29a. Certifier

4 ☐ Homicide

29b. Signature and title of certified

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

2001 Medical F

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

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and manner stated.

Yann

32/Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2009

09-04452 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Stephen Pronobis State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death 3. Time of Death June 4, 2009 **Medical Examiner** 0800 hrs Stephen Andrew Pronobis 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 11156 Bunch Berry Court Charles Waldorf 5. Social Security Number **Funeral** Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Months Days Hours Director Country) Florida 1XXM 2 F 595-25-4195 16 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No rmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland pearment of Health and Montal Hygiene.
portanet: If item 27 is marked inher than "natural", ur items 23a nr 28a-f she jury or nather traumatic event, the Modical Examiner must be notified at nace. Charles Waldorf <u>Maryland</u> Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 11156 Bunchberry Court 20601 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funera 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married Armed Forces White, etc. 1 Yes 4 Divorced Yes 2 No specify: 3 Widowed White If Yes, Give Year Specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 10th. Student High School 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Gary S. Pronobis Kim Marie Corwin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11156 Bunchberry Ct., Kim & Gary Pronobis/ Parents Waldorf, Maryland, 20601 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, Baltimore, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 crematory or other place) Removal from State June 11, 2009 Waldorf, Maryland Donation 5 Other Specify **Huntt Crematory** 22. Name and Address of Facility nature of Funeral Service Lig Huntt Funeral Home is a spirit with the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart sach line. Maryland 20601 Part I. Enter the disease, or **Physician** Approximate Interval failure. List only one cause de Between Onset and /Medical a. Hanging Examiner Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Eiseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical AMENDED 23a, 27, 28a-f, perME, G893 7/10/09 TT X UNPENDED attending physician or use as the burial of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy Month Year Day 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed has been 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of perform<u>ed</u>? this certificate ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) æ examiner? Hospital: 1 Other Nursing Home 5 Residence 6 🗸 Other Scene Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Natural Pending 1 Yes 2 X No subject hanged self Fd 6/4/09 FD 0730 hrs \_\_\_ Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) III 56 Bunch Berry Ct. Waldorf, MD 3 X Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be residence determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifies 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 5, 2009 30. Name and address of person who completed cause of death (Item 23a)

Registrar DHMH 17 Rev 1/2001

**OCME 2006** 

Russell Alexander MD.

31. Date filed (Month, Day, Year)

**ORIGINAL** 

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

32. Registrar's Signature

OCME

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		1- Für State Registrar 1. Decedent's Name (First, Midd		•	te of Deat				Reg. No.	20	0 9   8 8 3. Time of Death	
Physicia Medical Examin	ner	Eric S	teven Par	kinson				Month May 24, 2	Day 2009	Year	2323 hrs	
		4a. Facility Name (if not institution Bateman St & S. Sali	4b. City, Salis		Location of Death			County of Death	1			
Funeral Director		5. Social Security Number 217–25–2074		If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (9. Months Days Hours Min.								
any	ŀ	Usual Residence of Decedent  10a. State 10b. County	r Location					10d. Inside City Limits				
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with the Maryland ms 23a or 28a-f sho be notified at once.	Director	32967 Roy West Road				218	75			USA	intu y r	
or ite	Funeral	11. Marital Status  1 XNever Married 2 N	t Ever in U.S. ? X No	If Yes, speci	fy Cuban	panic Origin? ( S , Mexican, Puerto		White, etc.	ican Indian, Black,			
ours afte atural", taminer		3 Widowed 4 Di 15. Decedent's Education (Spe	vorced If Yes, Give Year or Dates: ecify only highest grade co	mpleted) 16a. D	ecedent's Usual	Occupat	specify: ion (Give kind of			Specify: WITCE  16b. Kind of Business/Industry		
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Itant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner.	Completed by	Elementary/Secondary (0-12)	2	2 chef						restaurant		
215-C oe filed v ntal Hygi ked oth	Be Co	17 Father's Name (First, Middle Dennis J. Pa				Jones	Maiden Surname)					
MD 2121 d 2 should be f lth and Mental n 27 is marked aumatic event,	2	19a. Informant's Name/Relation: Dennis Parkin	2967 Ro	Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Roy West Rd., Delmar, MD 21875								
Baltimore, Moemit. Pages 1 and 2 Department of Health Important: If item 2 injury or other traum		20a. Method of Disposition  1  Burial 2  Crematio  4  Donation 5  Other S	Disposition (Na ry or other place ns U.M. tery	Chur	cch 5/	Date 28/09	D	20c. Location - City or Town, State  Delmar, MD				
Baltimo permit. Page Department Important:		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804										
Physician /Medical caminer	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									Approximate Interval Between Onset and Death		
		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.										
	iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause										
ted Insit	Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.										
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial—tran	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)								l. Date of delive Month	ry Day Year	
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Division of Vital Records, tal or Attending Physician: The law requir rs after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should the control of the co	Completed								opsy formed?	prior to death?		
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on of Vit nding Physic th. : After this e funeral dir	ion: To	1 ✓ Yes 2 No  27. Manner of Death  1 Natural 5 Pen	,	JOA 4 Norsing Home 5 Nesidence 6 Control				er: Scene				
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the:	Certification	2 Accident 3 Suicide 4 Homicide  Accident 5 Could not be determined  Accident 5 Could not be determined  Accident 5 Could not be determined  Accident 6 Could not be determined  Accident 6 Could not be determined  Accident 7 Suicide 8 Place of Injury - At home, farm, street, factory, office building, etc. For Town, State 8 Bateman St & S. Salisbury Blvd, Salisbury										
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To t withi To t	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to and manner stated.  29b. Signature and title of certifier  29d. Date signed										
601		hig hi	) no		O.C.M.E. May 25,							
- ngo		30. Name and address of person who completed cause of death (Item 23a)  Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201										
St Regist		31. Date filed (Month, Day, Year)		ar's Signature	park							

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Division or Vital Records, P.O. Box 68760,

altimore, Maryland 21215-0036

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific: Completely filled in by the funeral director,

State Registrar

Medical

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier,

29c. License number 1588823827

Baltimore

29d. Date signed (Month, Day, Year)

D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22 Steppan 5. Greene Jochen

31. Date filed (Month, Day, Year)

29a. Certifier

MAY 28 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 's Name (First, Middle, Last, 2. Date of Death Time of Death Day Month Year 5120PM William 009 4c. County of Death 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltomore /ano If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12-28-1943 9. Birthplace (State or Foreign 5. Social Security Number Age (In yrs. last birthday) Months Days Hours Min. ountry) Delaware 65 217-42-5822 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 14 Yes 2 ☐ No Delaware Sussex Seaford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 19973 US 120 Holly Oak Dr 12. Was Decedent Ever in U.S. Armed Forces?

1X)Yes 2 No 196
If Yes, Give Year or Dates: 197 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 2 No 1967 1 ☐ Never Married 2 X Married 1 □Yes X□No Specify: White Specify: 1970 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Chemical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Franklin Phillips Erma Jane Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail Phillips - wife 120 Holly Oak Dr, Seaford,  $\mathsf{DE}$ 19973 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 5-29-09 ₩ Burial 2 Cremation 3 Removal from Millsboro, DE 4 ☐ Donation 5 ☐ Other (Specify) Delaware Veterans: Cem. ervice Lice 21. Sign ture of Funeral Cranston Funeral Home P O Box 967, Seaford, John A. Cranston 19973 DE23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) - one week Wesk if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last reumonia Due to (or as a consequence of) If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Alcohola Steatoherentry 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an

**Physician** /Medical Examiner

**Physician** 

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Maryland 21215-0036

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The law requires that the death certificate be executed

Box 68760

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Records,

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Division Hospital or Attending Examiner

Physician/Medical

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Be Completed

Medical Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 2110 1 ☐ Yes 1 🗆 Yes

rodules 25. Was case referred to medical examiner? 1 Yes 2 No

investigation

6 Could not be determined

5 Pending

1251 npatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifier

27. Manper of Death

1 Natural

2 Accident

4 Homicide

3 Suicide

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

Name and address of person who completed cause of death (Item 23a) (Type, Print)

7.

29d. Date signed (Month, Day, Year)

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month 11:2 TUNE IRENE FAYARD RUT 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death APLATA MEDICAL ENTER If Under 1 Year | If Under 24 Hrs. Date of Birth 1/2-30-1919 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Min. Months Days Hours ARGENTINA 579-24-7521 1 □ M 2 🖾 F 89 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State MD -CHARLES LA PLATA 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 20646 U.S.A. 1010 WASHINGTON AVENUE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ▼No Specify: SpecifyWHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) STATE DEPT. Elementary/Secondary (0-12) College (1-4or 5+) U.S.GOVT. TRANSPORTATION SUPERVISOR 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CECILIA P. FAYARD ISAAC M. FAYARD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ADAM CHARLES RUT-SON 1010 WASHINGTON AVE. LA PLATA, MD. 20646 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State METROPOLITAN CREMATORY 6-8-09 ALEX., VA. 4 ☐ Donation 5 ☐ Other (Specify) P.A. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MARYLAND 20646 21. Signature of Funeral Service Licenses M00479 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one complication at caused the death. Do not enter the on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown in the past 12 moni Year 5 Other (specify) g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of autopsy performed death? 1 ☐ Yes 1 ☐ Yes 2 40 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 ☑ Natural 28h Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

**Physician** /Medical Examiner o σ. Records, of Vital Physician: Division

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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Certification: To

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29a, Certifier

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**Funeral** 

Director

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item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at

n and Mental Hygiene.

Is marked other than "natural",

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau

2121

Baltimore, Maryland

After th funeral To the Hospital or Attending death. within 24 hours after death

To the Funeral Director:
completely filled in by the f

R

DHMH 17 Rev 1/2001

State Registrar

29b. Signature and title of certifier

NIRMALADEVI JAYANTHAN MD 3328 WASHINGTON
31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Deertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D-004

29d. Date signed (Mgnth, Day, Year)

Division of Vital Records, P.O. Box 68760,→ death.

Hospital or Attending Physician: The law requires that the death certificate be hours after deam. In 24 hours.

the Funeral Directory filled in by the completely

within To the

the

State Registrar

Certification: To

Medical

1 ☐ Yes 2 🕱 No

5 Pending

investigation

MD

6 Could not be determined

27. Manner of Death

1 Natural 2 ☐ Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 831 E. University Blvd #25 Kenneth Khandagle 31. Date filed (Month, Day, Year)

1 Inpatient

and manner stated.

Date of Injury (Month, Day, Year)

2 ER/Outpatient 3 DOA

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D 61007

1 ☐ Yes 2 ☐ No

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify)

Silver Spring, Maryland 20903

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

May 22, 2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2009 2:10 M **Physician** Month May 26, David Lee Reiter /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery General Hospital Olney Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 € M 2 🗆 F Director 330-44-4293 59 April 2, 1950 Illinois Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show or than "natural", or Items 23a or 28a-f show 1 ☐ Yes 2 No Directo Maryland Montgomery Gaithersburg 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 18928 Marsh Hawk Lane 20879 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: 196 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify þ 1968-74 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, in Magnes." Elementary/Secondary (0-12) College (1-4or 5+) Grants Administrator Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gaylord Milton Reiter Mary Louise Rosenboom ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Regina A. Reiter/Wife 18928 Marsh Hawk Lane, Gaithersburg, MD 20879 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State May 30 ᢂ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2009 Silver Spring, Maryland 22 Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd., W., Silver Spring, MD 20901 21. Signature of unegal Service Lice Voles 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final e 10ma **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): physician s the burial Box 68760 Physician/Medical attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) P.0. ed by the a signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed page 2 should 24a. Was an Were autopsy findings available prior to completion of cause of autopsy perform Division of Vital 1 ☐ Yes 2 ☐ No 1 ∐Yes funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending within 24 hours after death.
To the Funeral Director: investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 29a. Certifier 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) + D45014 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1811/ Prince Philip Drive Olney MD 20832 MD Martir Isabella 31. Date filed (Month, Day), Year) 32/1 State Registra

		For State	Sta	ate of Ma	aryland	-	artmer <i>rtifica</i> i				lental Hy	gien/ Reg. N	0 0	00	1.0	001
		Registrar  1. Decedent's Name (First, Mi	ddle, Last)				-				2. Date of D	eath	4	433	3. Time	or Death
hysici /Medic			Joseph		EPKO						May 30	), 2	009	Year		12:35 an
xamir	er	4a. Facility Name (If not instituted 13835 Greenf	-					, Iown, oi ugans		n of Death <b>le</b>		4		y of Death hingt		
neral		5. Social Security Number 109–26–1022	6. Sex 1 ☐ M 2		(In yrs. las	st birthday)  5 Yrs.	If Unde Months	r 1 Year Days	If Und Hours	er 24 Hrs. Min.	8. Date of B (Month, D Oct. 2	av. Yea	r)	9. Birth	place (State	-
ector		Usual Residence of Decedent									OCT. 2	.3,1	933	Penn	ısÿ1va	nıa
ied at	tor	10a. State 10b. Cou Maryland Wash	nty nington			Town or Lo									10d. Inside 1 ☐ Ye	City Limits s 2 □ No
st be notif	Funeral Director	10e. Street and Number 13835 Greenfi	eld Aver	nue			10f. Zi	Code 2	L767			10g. (	U.S	What Cou	int <b>ry</b> ?	
Important; it riem 27 is marked other than "naural", or rems 25a or 26a-1 show any Injury or other traumatic event, the <u>Medical Examiner must be notified at once.</u>	by	11. Marital Status 1 □ Never Married 2 □ Nover 3 □ Widowed 4 □ Divord	larried A	as Decedent E med Forces? □ Yes 2 1 N Yes, Give ear or Dates:			Was Dece If Yes, spe 1 ☐ Yes	ecify Cuba	lispanic an, Mexi Speci	can, Puerto	pecify Yes or N Rican, etc.)	lo-		ick, White	ican Indian, , etc. hite	
an natur e Medical I	Completed	(Specify only high		pleted) ollege (1-4or 5	+)	life.	kind of we DO NOT U	ork done ise retired	durina m	nost of work	king		Sb. Kind of Business/Industry garment factory			
nt, the	Š	12 17. Father's Name (First, Midd	lle. Last)	0	1		abor	er	18. Mo	ther's Nam	e (First, Middl				tactor	У
rked o	To Be	Mich		Scoran						A	gnes A	. Sa	y1or			
er trauma		19a. Informant's Name/Relati					•	•			ral Route Num Maugans					21767
nt: if item iry or othe		20a. Method of Disposition 1 ଔ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Othe		al from State	1	ce of Dispo metery, crea t Hav	_			Jun	Date e 2 2009			•	Town, State Mary	land
any Inju		21. Signature of Funeral Serv	Licensee Reu	her			2. Name a				Minnich					1 21740
ician		23a. Part1. Enter the disease shock, or heart failure.  Immediate Cause (Final disease or condition	, or complication List only one car	ns that caused use on each lin	the death.	Do not en	ter the mo		ng, such	as cardiac	or respiratory	arrest,			Approxim interval B Onset an	etween
dical and the prival-transit	dical Examiner	resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):														
To the funda birector, when this certificate has been signed by the awarding pro-	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2. No 9 □ ∪nknown	1 4	yes, outcome □Live birth □Pregnant at □Unknown	2 Fetal	death 3	□Ectopic p □ Other (\$		у					ate of deli	very Day	Year
n signed by uld be detac		Part II. Other significant con	ditions contribut	ting to death bu	ut not result	ting in the u	nderlying	cause giv	ven in Pa	art 1.	4	d tobacc	o use cor		the cause o	
page 2 sho	Completed by	Lyps Hyroi	dism		_	}					24a. Wa aut per 1 Yes	topsy rtorm <u>ed</u>	?	prior to c death?	topsy finding completion o	
rector,	Be	25. Was case referred to med examiner?	lical Hospit	al:		70.0		o. Oth	ner:		th (Check onl)		• ===			
funeral di	tion: To	1 Yes 2 No  27. Manner of Death  Natural 5 Pe 2 Accident inv		a. Date of Inju (Month, Day	ry	R/Outpatie 28b. Time o Injury		28c. Inju Wo	ry at		ome Re				orty)	
d in by the	Certification:	3 Suicide 6 □ Co	ild not be	e. Place of inju building, etc			reet, facto	ry, office			28f. Location City or 7			nber or Ru	ıral Route N	umber,
e Funera letely fille	Medical C		fylng Physician cal Examîner: (		f examinati											e(s)
duoo comb	Me	29b. Signature and title of cer	tifier	15		_	25	9c. Licens	t q	40		29d.	Date sign	ned (Month	h, Day, Year	)
3		30. Name and address of per いん、と、といても		red cause of d	eath (Item :	23a) (Type,	Print)	a f	ven	40 re 1	Vagers	ton	~	217	142	
Sta Regist		31. Date filed (Month, Day, Y	1 2009	32. Pegistra	ar's Signati	ure	are	,			V					

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State Registrar Brenner

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MEG

28 2009

21769

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Michael Reshetar, Jr. 2009 1:30 P M Mav /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Civista Medical Center LaPlata Charles If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 1 M M 2 □ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Director 192-30-3576 69 May 2, 1940 PA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 □Yes 2 No Director Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3164 Shadow Park Lane permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23s any injury or other traumatic event, the Medical Examinat must applied. by Funeral 20603 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Comunications Operator 12th. MD. State Police 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ( Michale Reshetar, Sr. Anna Michalyshin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine Reshetar/ Wife 3164 Shadow Park Lane, Waldorf, Maryland, 20603 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Mary's Ukrainian Cem. May 29, 2009 McAdoo. PA. 22. Name and Address of Facility Huntt Funeral Home 3035 Old Washington Rd. Waldorf, MD., 20601 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final **Physician** disease or condition resulting in death) OTOMAY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, and the list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown signed by the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown certificate has been s irector, page 2 should Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 WNo 1 ☐Yes 2 ☐No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifies 29d. Date signed (Month, Day, Year) DU647 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

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State

Registrar

31. Date filed (Month, Day, Year)

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el, mo

32.

29 2009

Post office Rd. waldows.

			State of Maryland / Depar	tment of Health and Me	ental Hygien	ie
			1 - State Registrar Certif	ificate of Death	Reg. N	6.2009 18864
	Physici	ian	Decedent's Name (First, Middle, Last)			Oay Year 3. Time of Death
-	/Medio	cal				009 6:42 P <sup>M</sup>
	Examir	ner	4a. Facility Name (If not institution, give street and number)  1160 Booker Drive	4b. City, Town, or Location of Death		Draings Coores In
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		8. Date of Birth	Prince George's  9. Birthplace (State or Foreign
П	Director		577-32-7259 1□ M 2対 F 82 Yrs.	Months Days Hours Min.	(Month, Day, Yea ec 5, 192	
	pur		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Local			10d. Inside City Limits
	Aaryla f sho	ō				1 DXYes 2 No
	the N	Director		pital Heights 10f. Zip Code	10g. C	Citizen of What Country?
	3a or		1160 Booker Drive	20743		USA
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Armed Forces? 13. Was 16 ft.	as Decedent of Hispanic Origin? (Spec es, specify Cuban, Mexican, Puerto R	cify Yes or No-	14. Race - American Indian,
36	or ite		1 Never Married 2 Married 1 Yes 2 No	es, specify cubail, Mexicall, Fuelto A ∃Yes 2 <b>X</b> ∃No <i>Specify:</i>	ican, etc.)	Black, White, etc.
21215-0036	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ont, the Medical Exprinter rout by norified at	ed by	3 ☐ Widowed 4 ☐ Divorced   Year or Dates:		40	BLack
15	in 72 n "na"	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kin	nt's Usual Occupation nd of work done during most of working ONOT use retired)	g 16b.	Kind of Business/Industry
212	d with giene ir thau	mo	Elementary/Secondary (0-12)  College (1-4or 5+)  Dept. 3	Store Clerk		Private
	be filed ntal Hygi ed other event, I	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maide	ən Surname)
<u>X</u>	2 should be filed within 72 hours after death with the Marylan and Mental Hyglene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Expriner was be notified at	2	Thomas Holmes	Edmon	ia Gray	
Maryland	s 1 and 2 should of Health and Mer item 27 Is marke other traumatic	6 7		Address (Street and Number or Rural	-	
e,	1 and 2 Health em 27 I	10	Donald Richardson (Son) 10401  20a. Method of Disposition 20b. Place of Disposition	46th Avenue #207	A, Beltsv	Location - City or Town, State
no	m		Cemetery, cremation 3 ☐ Removal from State			
altimore,		15	4 Donation 5 Other (Specify) Harmony Mer  21. Şignaturş of Funeral Service License 22. N	m. Park 6/4/	09	Landover, MD
ñ	permit. Departr Importa any inju	2 9	Vature Lating of 90	13 Annapolis Road	more Fune Lanham	eral Services, P.A.
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter a shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician	2.7	Immediate Cause (Final disease or condition Colon Cancer			Onset and Death
	/Medical	ш	resulting in death)  Due to (or as a consequence of):			2 Years
	Examiner	Ļ	Sequentially list conditions, b.			Z Tears
	rted nsit	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury			
	execu n and al-trai	xar	that initiated events c		<del> </del>	
8/60	icate be executed physician and the burial-transit	dical	d.			
D	certifica nding physe as th	ledi	IF FERMIS			
ROX	eath certific attending p for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant   in the past 12 months?   23c. If yes, outcome of pregnancy   1 □ Live birth 2 □ Fetal death 3 □ E	ctopic pregnancy		23d. Date of delivery
	the atten	sici		Other (specify)		Month Day Year
7.	e law requires that the de has been signed by the e 2 should be detached		Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I	23e Did tobacco	o use contribute to the cause of death?
ďS,	uires sign	d by	gg	mynig dadd gifdir ii'r ai'r ii		2∑ No 3☐ Probably 4☐ Unknown
Hecords,	law req as beer 2 shoul	Completed			24a. Was an	24b. Were autopsy findings available
	The la	dwo			autopsy performed?	prior to completion of cause of death?
VItal	sician: The certificate rector, pag	a l	25. Was case referred to medical	26. Place of Death	1 ☐ Yes 2 🐼 (Check only one)	No 1 ☐ Yes 2 ☐ No
O TO	Physician: this certific	To B	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	Othors		6 ☐ Other (Specify)
	ing P	ou:	27. Manner of Death 28a. Date of Injury (Month, Day, Year)  28b. Time of Injury Injury	Work?	3d. Describe how inj	jury occurred
<u> </u>	Attending or death. ector: Afte by the fune	cati	2 Accident investigation	M 1 □Yes 2 □No		
	or A after d Direc	Certification:	4 Homicide  determined  28e. Place of Injury - At home, farm, street, building, etc. (Specify)	, factory, office 28	If. Location (Street a City or Town, Sta	and Number or Rural Route Number, ate)
	spital		29a. Certifier Certifying Physician: To the best of my knowledge, death or	ccurred at the time, date and place, a	nd due to the cause	(s) and manner as stated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or invesone) and manner stated.	stigation, in my opinion, death occurred	d at the time, date a	and place, and due to the cause(s)
	Vithi Con	Ž	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
	, (		Maler / Parffer Mid	D0068056		5/28/09
	4		30. Marre and address of person who completed cause of death (Item 23a) (Type, Prin	DO068056  Mercantile La.	/	64.1
	- CI-			1 Mercantile La.	ne larg	10, Ma 20774
	Sta Registra		31. Date filed (Month, Day, Year)  32. Registrar's Signature	•		

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - For State Registrar	State of Mary		rtment of F rtificate of I			lene	0.0	1006	
Physic /Med		1. Decedent's Name (First, Middle, Last VIRGINIA L	SNY	deR			2. Date of Dea Month	th Day 30-20	Year	3. Time of Beath	
Exami		4a. Facility Name (If not institution, give NMS HEAITHCARE	<del>'</del>			r Location of Death ないい, ル		4c. County		STON	
Funeral Director	_	220 42 7200	x 7. Age (// ☐ M 2 🔀 F	n yrs. last birthday) 63 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day August	, Year)	Coun	lace <i>(State or Forei</i> try) yland	
Maryland a-f show ified at	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Washingt		Oc. City, Town or Lo					10d. Inside City Limits 1 <b>X</b> Yes 2 ☐ No		
or 28s	Director	10e. Street and Number	1		10f. Zip Code		1	l0g. Citizen of W	/hat Coun	try?	
23a cust b		South Prospect	Street		21740			U.S.A.			
ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	d by Funeral	11. Marital Status  1   Never Married 2  Married  3  Widowed 4  Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 □ Yes 2 ☑ No	Specify:	pecify Yes or No- o Rican, etc.)	o-  14. Race - American Indian, Black, White, etc.  Specify: white  16b. Kind of Business/Industry			
filed within 72 l Hygiene. other than "natent, the Medica	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retired nemaker	during most of wor	king	_	own		
should be filed and Mental Hyg marked othe umatic event,	To Be C	17. Father's Name ( <i>First, Middle, Last</i> )  David	Snyder			18. Mother's Nan	ne (First, Middle, Luella	Maiden Surnam Philpo			
1 and 2 sho Health and I tem 27 is me		19a. Informant's Name/Relationship (7.  James Tyrrell -	nephew	607	West Chu		et, Hage	rstown,	Mary	land 217	
Pages 1 Iment of H Iant: If ite		20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify	Removal from State	Hagerstov	matory or other place vn Cremat	ory May	Date 2009	20c. Location - Hagersto		Maryland	
permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licens	List		2. Name and Addre		Minnich /d., Hage	Funeral erstown,	Home Mar	yland 217	
Coate be executed // Medical Examiner sthe burial-transit		Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (bodde or night) that initiated events resulting in death) Last	a	onsequence of):						Onset and Death	
The law requires that the death certificat ate has been signed by the attending phy bage 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf p 1 ☐ Live birth 2 E 4 ☐ Pregnant at tirn 9 ☐ Unknown	Fetal death 3	⊒Ectopic pregnanc ] Other (s <i>pecify)</i> _	у		23d. Dat	e of delive	ery Day Year	
uires that signed b Id be deta	þ	Part II. Other significant conditions of	_	and the same		en in Part I.				ne cause of death? pably 4 <del>4Unkno</del>	
	Completed	ropethywid	in					rmed?	Were auto prior to co death?	psy findings availa mpletion of cause of	
ysician; is certific director,	To Be (	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatier	nt 3□ DOA Oth	or:	ath <i>(Check only or</i>		er <i>(Specif</i>	y)	
tter ding death. ctor After / the funer	Certification:	27. Manner of Death  1	28a. Date of Injury (Month, Day Y 28e. Place of injury building, etc. (	- At home, farm, str	M 1	ryat k? Yes 2 ⊡ No				al Route Number,	
To the Hospital or A within 24 hours after To the Funeral Directional Completely filled in by	Medical Co		ysician: To the best of r liner: On the basis of ex and manner stated	camination and/or in							
To the within To the comple	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signer			
1-0		30. Name and address of person who of VASA~T DAT			Print)	7 ha					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MAY 19, 2009 2:55  $A^M$ WILLIAM ARNOLD SHAFER /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HOLY CROSS HOSPITAL MONTGOMERY SILVER SPRING 5. Social Security Number 6. Sex 1 🛣 м 2 □ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 11/1/1933 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year Days Hours Min. Director 306-32-8204 75 Grammar,IN Usual Residence of Decedent show 10b. County 10c, City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f shovevent, the Medical Examinational by northed at 1KTYes 2 □ No Directo Maryland | Prince George's Forestville 10e. Street and Number 10g. Citizen of What Country? 5804 Burgess Road 20747 United States death 12. Was Decedent Ever in U.S. Armed Forces? 1 DYes 2 □ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter may injury or other traumatic event, the Medicel Exactina 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No þ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Comm. Manager Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Arthur Rolin Shafer Ilo Booker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Esther Shafer / Wife 7135 Timbercreek San Antonio, TX 78227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Arlington National 18/14/2009 Arlington, VA 22. Name and Address of FacilityPope Funeral Homes, P.A. 21. Signature of Funeral Service Licenses 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ASPIRATION PNEUMONIA WEEKS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ALZHEIMER'S DEMENTIA YEARS Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence or) attending physician and for use as the burial-transit be executed Examin DYSPHAGIA MONTHS resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.0. been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ SEIZURE HISTORY, TYPE 2 DM 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No cate has I page 2 s 24a, Was an autopsy certificate 1 ∐ Yes 2 🔀 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No filled in by the f 2 Accident 6 ☐Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

of Vital Records, Hospital or Attending Physician: Division To the Hospital within 24 hours a To the Funeral Completely filled

State

D0065485 RSW MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road Silver Spring, Maryland 20910 Barbara Supanich MD 32. Registr

Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

1 🗠 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month. Day. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar  Certifica	te of Death	Reg. I	2009 1000 No.
Physici	an/	Decedent's Name (First, Middle,Last)		Date of Death     Month     Date	3. Time of Death ay Year 1059 hrs
Medical Exami	ner	Virginia  4a Facility Name (if not institution, give street and number)	Smith  4b. City, Town, or Location of Deatl	May 19, 2009	9 TO39 TIIS
		Prince Georges Hospital	Cheverly	1	Prince George's
Funeral		Social Security Number			MM/DD/YYYY) 9. Birthplace (State or
Director		419-92-2264 1 M 2 X F 46	Yrs. Months Days Hours Mir	Dec.27	, 1962 Foreign Country) Alabama
Á		Usual Residence of Decedent  10a State 10b. County 10c. City. Town of	al contine		10d. Inside City Limits
ow any					1 X Yes 2 No
Aaryland 28a-f show	햕	Md Prince Georges Capit  10e. Street and Number	ol Heights 10f. Zip Code	10g.	Citizen of What Country?
he Ma 1 or 28 iffed 3	Dire	Md Prince Georges   Capit  10e. Street and Number  6504 Ronald Road	20743		USA
Baltimore, MD 21215-0036  sermit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Pytgeine. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho nijury or other traumatic event, the Medical Examiner must he notified at once.	Fal	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? ( S		14. Race - American Indian, Black,
death or iter	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puerto	o Rican, etc.)	White, etc.
s after ral", niner	ē	3 Widowed 4 X Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed) 16a. D	Yes 2 X No specify: ecedent's Usual Occupation (Give kind of	work dono	Specify: Black  Sb. Kind of Business/Industry
2 hour	Completed		uring most of working life, DO NOT use ref		b). Kind of Business/industry
036 ithin 7 ne.	ם	12 3	Housewife		Private
15-0 illed w Hygie		17. Father's Name (First, Middle, Last)		e (First, Middle, Maid	den Surname)
ID 21215-0036 should be filed within 72 hours after and Mental Hygiene. 7 is marked other than "natural", natic event, the Medical Examines	o Be	Herbert Glanton  19a. Informant's Name/Relationship (Type, Print )  19b	Mailing Address (Street and Number or		Cain  City or Town State Zin Code
MD 2 nd 2 shou alth and N m 27 is n	ပို		· ·		
Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and N inportant: If item 27 is n injury or other traumatic			5 0 4 Ronald Rd., C Disposition (Name of cemetery, ry or other place)	Date 20	Oc. Location - City or Town, State
Baltimore, permit. Pages I ar Department of Hes mportant: If ite		T Za Duriar 2 Cremation 3 Themoval nom state	rrection 5/	19/09	Clinton, Md
Balti permit. Departm Imports injury o		21 Signature of Funeral Service Licensee	22. Name and Address of Facility B 1	uford Fu	neral Service,LLC
	W X	23a, Part I. Ento the disease, or complications that caused the death. Do not	2019 MLK Ave. S	E, Washi	ngton, DC 20020 shock, or heart Approximate Interval
Physician /Medical	. 3	failure. List only one cause on each line.		or respiratory arrest,	Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death)  a Fentany1 intoxic Due to (or as a consequence of):	ation		
		Sequentially list conditions, b			
	ine	if any, leading to immediate Due to (or as a consequence of):			
sit id	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			-
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760, ficate be ex g physician the burial	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy		1	23d. Date of delivery
		23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pregn	ancy	Month Day Year
Box 68's death certification attending	Physician	4 Pregnant at time of death 5   1	Other (Specify)		
that the done by the detached	P.	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
res that signed lbe det	d by			1 Yes	2 No 3 Probably 4 ✔ Unknown
ords  v requires been should	Sete			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Vital Records, ysician: The law requir his certificate has been if director, page 2 should	Completed			performe 1 <b>Y</b> Yes 2	
ian: ]	Be	25. Was case referred to medical examiner?	26. Place of Death (Check	only one)	
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the safter death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	၉	1 Yes 2 No Inpatient 2 V ER/Ou	patient 3 DOA Other Nursi	ng Home 5 Res	sidence 6 Other:
nding Pt nding Pt th. : After e funeral	<u>io</u>	1 Natural 5 Roading (Month, Day, Year)	1 Yes 2 V No	unknown	mijary occurred
'isio 'Atter er deat rector	icat	2 Accident Investigation FG 5/19/09 FG 28e. Place of Injury - At home, far	m, street, factory, office building, etc.		et and Number or Rural Route Number, City
Division of Paptal or Attending Phons after death.  Peral Director: After I filled in by the funeral	Certification:	3 Suicide 6X Could not be determined (Specify) found a	t home	or Town, State Capitol 1	e)6504 Konald Kd Heights, MD
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dear			
To the Hos within 24 h To the Fur completely	ledical	one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurred  29c. License number		d place, and due to the cause(s)  9d. Date signed (Month, Day, Year)
	Σ	29b. Signature and title of certifier	O.C.M.E.		May 21, 2009
		30. Name and address of person who completed cause of death (Item 23a)			
B		Patricia Aronica-Pollak MD. Assistant Medical Exami	ner 111 Penn Street, Baltimo	re, MD 21201	
	tate	31. Date filed (Month, Pay Year) 5 2009 32. Registrar's Signature.	parker		
Regis	Tall	DOLL OF COMMENT	7		

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-04320 State of Maryland / Department of Health and Mental Hygiene Christopher Michael Smith 1- For State Certificate of Death Reg. No Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day May 30, 2009 1501 hrs **Medical Examiner** Christopher Michael Smith 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Charles 6180 Landsdale Place Bryantown 9. Birthplace (State or 8. Date of Birth (MM/DD/YYY) If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director Country) 213**-**19-9329 1 X M 2 F 29 Yrs Maryland January Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2XX No 28a-f shov Maryland Charles Bryantown "natural", or items 23a or 28a-f sho | Examiner must be notified at once. 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number ā 6180 Landsdale Place 20<u>617</u> 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No Funeral 11. Marital Status Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married Married 2 X No Yes White Yes 2 No specify: Specify: f Yes, Give Year within 72 hours after Widowed Divorced ò 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) timore, MD 21215-0036

1. Pages I and 2 should be filed within 72 h

Timent of Health and Montal Hygiene.

Trant: I fitem 27 is marked other than "n

y or other transmatic event, the Medical E Elementary/Secondary (0-12) the Medical HFSO Land SurveyorCo 12th. and Surveyor 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Alexander Smith Jeanne Carre 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6180 Landsdale Place. Bryantown MD 20617
Date 20c. Location - City or Town, State Jeanne Mahonev/ Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Trinity Mem. Gardens Department o June 5, 2009 Waldorf, Maryland Donation 5 Other Specify: 22. Name and Address of Facility anature of Funeral Service Licensee Huntt Funeral Home 3035 01d Washington Rd. Waldorf, M 20601 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Physician Between Onset and failure. List only one cause on each line Death **Medical** a Heroin intoxication Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical 23a,27,28a-f,perME g892 6/12/09 TT attending physician a X UNPENDED AMENDED Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Month Day Fetal death 3 Ectopic pregnancy Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown q Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. Part II. Other significant conditions þ No 3 Probably 4 ✔ Unknown 1 Yes 2 Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? . death? 2 No ✓ Yes 2 1 🗸 Yes certificate 26.Place of Death (Check only one) 25. Was case referred to medical of Vital the Hospital or Attending Physician: Be Other<sub>4</sub> Hospital: examiner? Nursing Home 5 Residence 6 ✔ Other: Scene DOA Inpatient 2 ER/Outpatient 3 this No ٩ 1 V Yes 28d. Describe how injury occurred the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: unk Natural 1 Yes 2X No Division Pending 5/30/09 Fd 2:49 pm Fd 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number City or Town, State) 6180 Landsdale Plaryantown, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc within 24 hours after d To the Funeral Direct completely filled in by 6 X Could not be 3 Suicide Found: residence determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number May 31, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ling Li, MD

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

31. Date filed (Month, Day Year) 8 2009

32. Registrar's Signature

Cenewa

			For State	State of Mar		artment of H		d Mental Hyg	iene <sub>eg. No.</sub> 20	09	18869
			Registrar  1. Decedent's Name (First, Middle, Las	st)		Timouto or I	504111	2. Date of Dea	th		3. Time of Death
н	Physici /Medic		Betty LeComp	te Smith				May 2	7 Day 200	9 <sup>Year</sup>	12:40a.™
\$	Examin		4a. Facility Name (If not institution, give 113 Talbot Ave	,		4b. City, Town, or Cambri		Death	4c. County Dor	of Death chest	er
Ü	Funeral		5. Social Security Number 6. S	DM WTE	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Birth Min. (Month, Day	, Year)	9. Birthp Coun	lace (State or Foreign stry)
ů,	Director		220-07-0394 Usual Residence of Decedent	87	Yrs.			July 17	, 1921	Mary	land
	land t		10a. State 10b. County	1	10c. City, Town or Lo	ocation				1	0d. Inside City Limits
	Mary -f sho fied a	후	MD Dorche	ster		Car	mbridge	е			1X Yes 2 □ No
3	r 28a	Director	10e. Street and Number			10f. Zip Code			0g. Citizen of V	Vhat Cour	ntry?
Ź	th wit	a D	113 Talbot Av	enue e		216	13		USA		
Maryland 21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No	lispanic Origin an, Mexican, P Specify:	? (Specify Yes or No- Puerto Rican, etc.)		e - Americ k, White, /: <b>W</b> h	
Õ	72 ho	ted	15. Decedent's Ec	lucation	16a. Dece	dent's Usual Occup	ation	f working	16b. Kind of Bu	siness/Ind	dustry
21	ithin 7 ne. nan "r Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done of DO NOT use retired		Working		,	
2	filed within Hygiene. other than '		17 Fether's Name / First Middle / set			homema		Name (First, Middle,		home	2
and	ould be fi Mental H arked otl atic ever	Be	17. Father's Name (First, Middle, Last) Howard Thomas I					Burton	waiueri Surriari	ie)	
٦	2 should be and Mental is marked or raumatic even	욘	19a. Informant's Name/Relationship		19b. Maili	ng Address (Street		or Rural Route Numbe	r, City or Town,	State, Zir	Code)
Ĭ	and 2 sealth ar n 27 is		Russell P. Smith			,		mbridge, M		_	,
ē,	s 1 al f Hea ifem othe		20a. Method of Disposition		20b. Place of Disp	osition (Name of matory or other place	re)	Date	20c. Location -	City or To	own, State
Ë	Pages nent of I ant: If ite		1 ☐ Burial 2 🖾 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		,	y Cremato	- i	5/28/09	Salis	oury,	MD
Baltimore,	permit. Pages 1 and 2 Department of Health s Important: If Item 27 is any Injury or other tra once.		21. Signature of Funeral Service Licer	see		2. Name and Addre		Thomas Fur Cambridge		ome F 1613	.A.
г			23a. Part . Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line	he death. Do not en	ter the mode of dyir	ng, such as ca	rdiac or respiratory are	rest,		Approximate Interval Between Onset and Death
3	Physician		Immediate Cause (Final disease or condition	a. Chronic	obstruct	Tive Pulmo	mary o	Disease			15 years
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):						(
ž.		-	Sequentially list conditions,	b. — Due to (or as a	consequence of			-			
	nted Insit	min	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury								
Ć	ate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a	consequence of):			· -			
8760,	te be ysicia ie bur	cal		_d							
9	rtifica ng ph as th	/ledi	IF FEMALE:								
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-	ne des the at hed fo	/sici	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at tii 9□Unknown	me of death 5	Other (specify)				71111	Duy Tour
P.0	that the ed by the detache		Part II. Other significant conditions of	ontributing to death but	not resulting in the u	ınderlyina cause aiy	en in Part I.	23e. Did to	bacco use con	tribute to t	he cause of death?
ds,	w requires that been signed to should be deta	d by		g		,g g.		1 <b>™</b> Y	es 2 No	3 ☐ Pro	bably 4 □Unknown
Sor	v requ	ete						24a. Was a	an 24h	Were aut	opsy findings available
Re	has Je 2	Completed						— autop perfo	sy med?	prior to co death?	mpletion of cause of
tal	sician: The certificate rector, pag		25. Was case referred to medical				26 Place of	1  Yes f Death (Check only o		1 ∐Yes	2□No
>	Physician: r this certifica ral director, p	To Be	examiner? 1 □ Yes 2☆ No	Hospital: 1 ☐ Inpatient	t 2 ☐ ER/Outpatie	nt 3 DOA Oth	OF:	ing Home 5 Resid		ner (Speci	fy)
0 0	ding Ph n. After th funeral		27. Manner of Death  1 X Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time (	of 28c. Injur		28d. Describe h			
Sio	Attending r death. ector: After by the fune	atic	2 ☐ Accident investigation	1 -			Yes 2 □ No				
Division or Vital Records,	or Attencatter death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury building, etc.	y - At home, farm, st <i>(Specify)</i>	reet, factory, office		28f. Location (S City or Tou		per or Run	al Route Number,
	pital o		29a. Certifier Certifying Ph	ysician: To the best of	mu knowlodgo, doo	th convered at the ti		whose and due to the	(a) and m		ntatod.
	Hos 24 ho Fun etely	Medical		niner: On the basis of e and manner state	examination and/or i						
	To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral	Me	29b. Signature and title of certifier	7 0 /	7	29c. Licens	se number		29d. Date signe	d (Month,	Day, Year)
	- > 0		1/1/1	XV	MI	Do	0804	4	M.	27	2009
	10		30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type	, Print)	,		- my		50-1
_	U		Mark Malke	L, MD.	408 E	3ym st	reet	Cambrio	lae, 1	ND	21613
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar	's Signature	and I			J /		

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Day Year Stalling 48 M obin 141 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town or Location of Death 4c. County of Death Examiner land Medical Center Mary Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 □ M 2 🕱 F MARYLAND 67 AUGUST 4, 1941 Director 219-40-0510 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar in tal be refilled at 10d. Inside City Limits Director 1 ☐ Yes 2 X No **MARYLAND** CAROLINE DENTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 309 FLEETWOOD ROAD 21629 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: WHITE ≥ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) HORSE Elementary/Secondary (0-12) College (1-4or 5+) . Pages 1 and 2 should be filled wi fment of Health and Mental Hygien tant: If Item 27 is marked other th jury or other traumatic event, Ins 12 MINIATURE HORSE BREEDER BREEDING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ROBERT STALLINGS ည MARTE BELL. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KAREN KILHEFFER/LIFE PARTNER 309 FLEETWOOD ROAD, DENTON, MARYLAND 21629 permit. Pages 1 am Department of Heal Important: If Item 2 any Injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition MAY 30 20c. Location - City or Town, State 1 MBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 2009 MEMORIAL CEMETERY ANNAPOLIS, MARYLAND 21. Sign une of Funeral Service Licus 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A al 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** Secondary Sis disease or condition resulting in death) month /Medical Due to (or s a consequence of): Examiner torat if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Candidenia and Due to (or as a consequence of): burial-1 Division of Vital Records, P.O. Box 68760, signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 ☑ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 acidosis 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate perforn 2 🗆 No 1 □Yes 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending death. investigation 1 ☐ Yes 2 No 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

24 hours after death Funeral Director: within 2

State Registrar

Medical

Jacen 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a, Certifier

(Check only one)

Pourshant 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28 2009

Do

park

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

417-16-120

29d. Date signed (Month, Day, Year)

S. GREENE ST BACTEMORE MD 21201

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May 21, 2009 William Frank Schrom 9:00 РМ 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Bowie Health Care Center Prince George's Bowie If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 XM 2 □ F 577**-**32-8306 78 March I, 1931 Tennessee Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 V Yes 2 □ No Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2808 Blue Jay Lane 20715 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 □ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Tyes 2 No 1948 If Yes, Give 1948 Year or Dates: 1953 1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 XNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Management Telecommunications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ralph Henry Schrom Buelah Jane Bennett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorna Schrom/ Wife 2808 Blue Jay Lane Bowie, MD 20715 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 5/23/2009 | Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Puneral Service Licensee 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Due to (or as a consequent of): Sequentially list conditions Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy 2 No 1 □Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗖 No 1 Tyes 1 ☐ Inpatient 2X ER/Outpatient 3 ☐ DOA 27. Manno of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 A atural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Physician/Medical 2 Completed

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Certification: To

Medical

Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Michael France.

**Physician** 

the Hospital or Attending Physician: The law requires that the death certificate be executed that 24 hours after death. The Latens are death. Fureral Director: After this certificate has been signed by the attending physician and reletely filled in by the Internal director, page 2 should be detached for use as the burnal-transit

P.O. Box 68760,

Division of Vital Records,

/Medical Examiner

25. Was case referred to medical examiner?

6 Could not be determined 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certifier

00060120

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4000 mitchellville Rd Bowle and 20716 W. Hagethma 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

27 2009

To the within 2

			State of Maryland / Departm		/lental Hygi	iene	
	_		Registrar  1. Decedent's Name (First, Middle, Last)	cate of Death	2. Date of Death	eg. No. 2009	3 Time of Death
П	Physici /Medio		Max Mahmood Shams			26 / 2009	8:39 a <sup>M</sup>
-	Examir			City, Town, or Location of Death		4c. County of Death	
esta de		ш	Shady Grove Adventist Hospital	Rockville		Montgo	
ĺ.	Funeral Director		225-77-3222 15x 2□ F 72 Yrs. Mon	nder 1 Year   If Under 24 Hrs. ths Days Hours Min.	8. Date of Birth (Month, Day, 09/29/	9. Birth Cou	place (State or Foreign intry) Iran
	land		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Mary Ind	tor	MD Montgomery Gait	hersburg			1 □Yes 2√ No
	or 28s	)ire	10e. Street and Number 10f.	. Zip Code	10	ng. Citizen of What Cou	ntry?
	ath wi	ral	224 Lazy Hollow Dr.	20878		USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Madical Examination to other traumatic event, it a Madical Examination to other traumatic event.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give 1 Yes Year or Dates:	ecedent of Hispanic Origin? (Sp specify Cuban, Mexican, Puerto s 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White, Specify: P	
9	2 hou			Usual Occupation	1	16b. Kind of Business/Ir	
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	iled w Hygiei <b>ther tf</b> nt, th	Co	17. Father's Name (First, Middle, Last)	.neer	/Eirot Middle A	Agricul	ture
Baltimore, Maryland	should be fand Mental I s marked of umatic eve	To Be		Sakin		vashi	
lary	2 shou and N is mai	-		ress (Street and Number or Rur	al Route Number,	City or Town, State, Zi	p Code)
6,≤	and health			zy Hollow Dr			
10r	ages 1 nt of 1- t: If Ite		20a. Method of Disposition  20b. Place of Disposition cemetery, crematory  20c. Place of Disposition of cemetery, crematory	i .		20c. Location - City or T	
Ħ	nit. Partme ortani injun	ď		e and Address of Facility		Rockville al Mortua	
ä	permi Depa Impo any ir	r J	1/4.2. 1/1/4.4.	Kennedy St N			DC 20011
		4	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the	mode of dying, such as cardiac	or respiratory arre		Approximate Interval Between
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	/Medical Examiner		Due to (or as a consequence of):				
	E - 10	Jer	Sequentially list conditions, bb				
	acuted nd rransit	Examiner	that in the control of the control of the cause. Enter Underlying Cause (Disease or injury that initiated events				
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68760,	ficate physics the b	edical	d				
Box (		n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deliv	verv
O. B	The law requires that the death cert ate has been signed by the attending age 2 should be detached for use a	Physician/M	in the past 12 months?  1	oic pregnancy r (specify)		Month	Day Year
σ.	ires that the de signed by the a I be detached f		Part II. Other significant conditions contributing to death but not resulting in the underlying	ng cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
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ဝ၁၁	e law re has be e 2 sho	Completed			24a. Was an		opsy findings available ompletion of cause of
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Vita	sician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Deat			
ō	this al di	2	27. Manner of Death 28a. Date of Injury 28b. Time of	4 Nursing Ho	me 5 Resider	nce 6 Other (Spec w injury occurred	ify)
Ö	ath. rr: After	atio	1 Natural 5 □ Pending (Month, Day, Year) Injury 2 Accident investigation M	Work? 1 □Yes 2 □ No			
Division of	tal or Attendii s after death, al Director; A ed in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, face building, etc. (Specify)	ctory, office	28f. Location (Str. City or Town,	reet and Number or Rui , State)	al Route Number,
	spital ours a neral C		29a. Certifier 1 rtifying Physician: To the best of my knowledge, death occur	rred at the time, date and place	and due to the ca	ause(s) and manner as	stated
٨	To the Hospital or within 24 hours after To the Funeral Direction completely filled in the formula of the formu	Medical	(Check only one)  Medical Examiner: On the basis of examination and/or investiga and manner stated.	tion, in my opinion, death occur	red at the time, da	ate and place, and due	to the cause(s)
t	To t withi	Σ	29b. Signature and title of certifier	29c License number	29	d. Date signed (Month	Day, Year)
			THE ME	2 57024	1	4Ay 26	2009
	3		ame and dress of rson was completed cause of Seath (Item 23a) (Type, Print)	Combany	1	/ /	
	Stat	e	9901 Medical of. Date filed (Month, Day, Year) 32. Registrar's Eignatury	Center Dr. R	ockvill	<b>∉,</b> MD 208	350
	Registra	ır	1. Date filed (Month, Day, Year)				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 2 pr dr., g892,06/29/09dhb Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Deat 05/20/2009 3. Time of Death Month **Physician** 2235 Winston Trumbauer Joseph /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Social Security Number 6. Sav 4/1000100 50/1364R Teninsula 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Months Days 1 XM 2 ☐ F 216-38-8463 Jan 4, 1942 New York Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director MD Somerset Princess Anne 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 10441 Stewart Neck Road <u> 21853</u> USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: White Specify: <u>م</u> 3 ☐ Widowed 4 🛛 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Agriculture Agriculture Agent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kenneth Trumbauer Donna Sloniker ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Holland (daughter) 3847 Whitesburg Rd., Pocomoke City, MD 21851 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/23/2009 Salisbury Crematory Salisbury, MD 22. Name and Address of Facility Holloway Funeral Home, Professional Association 107 Vine St., Pocomoke City, MD 21851 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final hema toma subdural disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day 1 ☐Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ med pritony Choru 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ∐Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Maryes 2 □ No 1 Mainpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending 5/10/09 1 □ Yes 2 🗗 No investigation 1900 2 Accident

Physician /Medical Examiner law requires that the death certificate be executed

**Funeral** 

**Director** 

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ir than "natural", or items 23a or 28a-f show the Wedical Examinational be mutilied at

Maryland

with the

death v

filed within 72 hours after

Pages 1 and 2 should be

nd Mental Hygiene.

Department of Health and Menta Important: If item 27 Is marked any Injury or other traumatic evonce.

Maryland 21215-0036

Saltimore,

Box 68760.

P.O.

Records,

Division of Vital

Attending

sician and burial-transit attending physician for use as the burial signed by the a cate has been signated by page 2 should b certificate | funeral director, this After t To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft

Certification: To

fall

28f. Location (Street and Number or Rural Route Number, City or Town, State) 220 Tilgwan Kd Salishuer

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Renab Center 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

29b. Signature and title of

6 Could not be

determined

450497

30. Name and anticss of person who completed cause of death (Item 23a) (Type, Print) Carroll St. Salsbury, MB. Snyder m.C. 100 E.

31. Date filed (Month, Day, Year)

3 Suicide

29a. Certifier

Medical

State Registrar

4 Homicide

(Check only one)

MAY 28 2009

32. Registrar's Signature

BA5

Please Type or Print in Black Indeline 1996. Frappos Alk Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death  $\mathbf{P}^\mathsf{M}$ 12:20 2009 William Henry Thomas May 4c. County of Death Center 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Takoma Park Sligo Creek Nursing Rehabilitation | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Oct. 31, 1914 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 1 XM 2 □ F Country 577-40-9253 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 X Yes 2 ☐ No Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20011 United States 240 Peabody Street, NW 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 X Married Black 1 ☐Yes 2 XNo Specify. 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed Businessman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William . Thomas Hilda Bell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara G. Wells/ Niece 1364 S. Curson Ave. Los Angeles, CA 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other t Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Harmony Memorial May 29, 2009 Landover, MD 4 ☐ Donation 5 ☐ Other (Specify) ark 21. Signature Fineral Service Licent 22. Name and Address of Facility Stewart Funeral Home, Inc. 20019 4001 Benning Rd. N.E. Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Atherosclerosis Cardiovascular Disease Due to (or as a consequence of) Sequentially list conditions, if or y is John Scause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 □ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Odt. Mass subsess findings

**Physician** /Medical **Examiner** Hospital or Attending Physician: The law requires that the death certificate be executed

**Physician** 

Examiner

**Funeral** 

Director

28a-f show

items 23a or 28a-f showner must be notified at

'natural", or

and Mental Hygiene.

Department of Health a Important: If Item 27 is any injury or other tra

Director

Funeral

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Completed

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

physician and s the burial-trans attending p for use as t certificate has been signed by the rector, page 2 should be detached ours after death.

neral Director: Ailed in by the fu

Division of Vital Records, P.O. Box 68760,

Examine Physician/Medical þ Completed Be Certification: To

Medical

State

Registrar

						autopsy performed?  1 Yes 2 ANo	prior to completion of cause or death?  1 □ Yes 2 □ No				
25. Was case refer examiner?	red to medical			26. F	Place of Death (	th (Check only one)					
1 Yes 2 🔀	[No	Hospital: 1 Inpatient 2 I	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4 M Nursing Home 5   Residence 6   Other (Specify)								
27. Manner of Deat 1 X Natural 2 Accident	5 ☐ Pending investigation		28b. Time of Injury M	28c. Injury at Work?		28d. Describe how injury occurred					
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		ome, farm, street, factory)	ry, office	281	f. Location (Street an City or Town, State	d Number or Rural Route Number, )				
29a. Certifier (Check only one)	1 X Certifying Ph 2 Medical Exam	hysician: To the best of my knominer: On the basis of examination and manner stated.	wledge, death occurre ation and/or investigati	ed at the time, da on, in my opinion	te and place, an , death occurred	d due to the cause(s) at the time, date and	and manner as stated.  I place, and due to the cause(s)				

29c. License number

D0060100

29d. Date signed (Month, Day, Year)

May

26,

2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Tahmina K. Ahmed, MD 831 University Blvd, E Suite 27 Silver Springs, MD Date filed (Month, Day,

MAY 2 8 2009

29b. Signature and title of certifier

32. Registrar's Signature Garde

			Amend Items 23	pe or Print in Bla art 1,25,27,28a State of Maryland	ck Indelible Indelible Indelible Indelible Department of	Ensure / 92,06/19/ Health and	<b>II Copies Ar</b> 09dhb Mental Hygiei	<b>e Legible.</b> ne	
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	Physic /Medi		Jacob	Turlington	J SR.		May &	23. 2009	0759 M
180	Exami		4a. Facility Name (If not institution, give st	reet and number)		or Location of Deat	h /	4c. County of Death	
-				several HUSP.		ubridg	e	Dorche.	ster
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	Months   Days		8. Date of Birth (Month, Day, Yes	9. Birth	place (State or Foreign ntry)
	Director		Usual Residence of Decedent	89	Yrs.		Nov. 24,1	1919 Vin	ginia
	and w		10a. State 10b. County	10c. City, To	own or Location			-	10d. Inside City Limits
	Maryland	ō	MD David						1 Yes 2 No
7	the 1	rec	MD Dorche.  10e. Street and Number	ster C	ambridge 10f. Zip sode		100	Citizen of What Cou	ntry?
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R	leath	era	1001 Washir	Was Decedent Ever in U.S.			necify Yes or No-	14. Race - Ameri	can Indian
(0	after o	표	1 ☐ Never Married 2 ☐ Married	Armed Forces?	13. Was Decedent of If Yes, specify Cub		o Rican, etc.)	Black, White,	
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5-0036	72 hours natural", dical Eve	Completed	15. Decedent's Educa	tion I 10	Sa. Decedent's Usual Occu		16b.	Kind of Business/In	
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2	filed within Hygiene. Ither than "	ပ္ပြ	3		vel Deliv	ery Ma	N HE	eating fue	1 Contractor
nd	tal H	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nar	ne (First, Middle, Maid	len Surnane)	
Maryland	should be tand Mental s marked o umatic eve	ြို	Unknow	n		Un	KNOWN		
lar	2 sho s and is ma		19a. Informant's Name/Relationship (Type		9b. Mailing Address (Street				· _
	ges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the "Medical Exeminer must be notified at		Jacob turlir		1960 SKee	t Club x	2d. Hurlo		
9	Pages 1 nent of H int: If ite		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ Rer		of Disposition (Name of tery, crematory or other pla			Location - City or To	
Ë	Living Pa		4 ☐ Donation 5 ☐ Other (Specify)	Wave	7h Cemete	ry 15/3	31/09 C	ambridg	e, MD.
Baltimore	permit. Pages 1 al Department of Hec Important: If item any Injury or othe		21. Signature of Funeral Service Licensee	21	22. Name and Addre	es of Facility	Home, P. A.	,	,
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-	Physician		Immediate Cause (Final disease or condition	Preumon	a			1	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence			,		a weeks
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	sit is	ine	Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury	Due to (or as a consequence	e of):	1 N	EXAMINE.	R	
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-	75		Konal Failure A	nd Osteoporo	sis	l	1 □ Yes 2 🗹		2 PNo
Ξ	Physician: r this certificaral director, p	Be	25. Was case referred to medical examiner?	pital:	Ott		th (Check only one)		
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Division	ding th. Afte fune	ţį	1 Natural 5 Pending 2 Accident investigation	Found, Day, Year)	Injury Wor	k? Yes 2 <b>K</b> INo	Subject		
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ă	afor after	Certification:	4 ☐ Homicide determined	building, etc. (Specify)  Home	, , , , , , , , , , , , , , , , , , , ,		City or Town, St. Cambridge	ate) 1001 Wa	shington St
	To the Hospital or Attending Physician: within 24 hours after death within 25 hours after death of the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying Physic	ian: To the best of my knowled	ge, death occurred at the ti	ime, date and place	and due to the cause	e(s) and manner as	stated.
	n 24 n 24 ne Fu	Medical	(Check only 2☐ Medical Examine one)	On the basis of examination and manner stated.	and/or investigation, in my	opinion, death occu	rred at the time, date a	and place, and due t	o the cause(s)
	Som this	Ž	29b. Signature and title of certifier	100	29c. Licens	se number	29d.	Date signed (Month,	Day, Year)
	x\		Mon al	Ja DU.	1 H	44 615	4/24	1/09	
	18,	Ì	30. Name and address of person who comp	eted cause of death (Item 23a	) (Type, Print)	110.0	Jan 1	1	
			Lois A. NARR/	D.O. 100	Bromble:	St C.	mb did a	e mi	)
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	h - ed 1		(	1	
	Registra	ar	MAI NO CUU	James B.	The state of the s				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Helen M. Tierney 21 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 693 Faircastle Avenue Severna Park | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Apr. 30 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 21 F 161-18-6247 Director 88 Pennsylvania 1921 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy loury or other traumatic event, the Musical Examiner must be rediffed at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tyes 2 No MD Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 693 Faircastle Avenue 21146 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Westinghouse 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Victoria Baligrocky John Dzmura 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Tierney/Husband 693 Faircastle Avenue Severna Park, MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 🔀 Removal from State May 28, St. Mary's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Munhall, PA 2009 22. Name and Address of Facility Barranco & Sons, Severna Park Funeral Home P.A. 495 Gov. Ritchie Hwy. Severna Park, MD 21146 23a. Part enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unsease or injury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and each given by the funeral director, page 2 should be detected for use as the burial-transit each, filled in by the funeral director, page 2 should be detected for use as the burial-transit physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☑No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ THRIVE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a ts Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D57531 MAY 21, 2009 who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of persol

31. Date filed (Month, Day, Year)

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8601 Veter and How

32. Redistrar's Signature

264 millemelle, MD 2/18

			1 - For State Registrar	State of Ma	ryland /		artment of I rtificate of					
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~¥	Examir	ıer	4a. Facility Name (If not institution, give Tate Hospice Ho				4b. City, Town, CLintl				4c. County of De	
- 1	Funeral		5. Social Security Number 6. Se		(In yrs. last b	irthday)	If Under 1 Year	If Und	er 24 Hrs.	8. Date of Birth	9. Bi	irthplace (State or Foreign
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	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tov	vn or Lo	cation					10d. Inside City Limits
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	or 28.	Director	10e. Street and Number				10f. Zip Code				log. Citizen of What C	Country?
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920	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Modical Examinar must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ex Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	ver in U.S.		Nas Decedent of fYes, specify Cub I□Yes 2ሺNo			city yes or No- Rican, etc.)	14. Race - Am Black, Whi	
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altimore, Maryland 21215-0036	filed within Hygiene. other than "ent, tre Mes	Completed	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	College (1-4or 5+	)	Boo	kind of work done DO NOT use retire Keeper	т			Computers	
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Jre,	es 1 and 2 of Health item 27 i		20a. Method of Disposition		20b. Place	of Dispos	sition (Name of natory or other pla	ice)	Di	ate	20c. Location - City o	r Town, State
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Divis	To the Hospital or Attending Physician: The within 24 Hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification: To	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	y - At home, fa (Specify)	arm, stre	eet, factory, office		2	8f. Location (Si City or Town	treet and Number or F n, State)	Rural Route Number,
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			30 Name and address of person who co	ompleted cause of dea	ath (Item 23a)	(Type F	Prints	VI	428		may 26	,2009 Our MAZIYY
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	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar	s Signature							

Registrar

MAY 27 2009 Setur B. Jak

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 05/20/20<sup>Day</sup> **Physician** 07:27 AM C. Townsend /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Wicomico Salisbury 29873 Riverside Dr. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1**X**]M 2□F Yrs 08/11/1924 Director 218-16-5986
Usual Residence of Decedent Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "naturel", or items 23e or 28a-f show any injury or other traumatic event, the Madical Exemples. 10a. State 10b. County 10c. City, Town or Location 10d. toside City Limits 1 ☐ Yes 2 X No Director Salisbury Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21801 26873 Riverside Dr. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Carpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alda Washburn Atwood Townsend 19a. Informant's Name/Relationship (Type, Print) 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26873 Riverside Dr. Salisbury, Maryland 21801 Doris Townsend/wife 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Springhill Memory \* 4 ☐ Donation 5 ☐ Other (Specify) 5/22/2009 Hebron Maryland Gardens 21. Signature of Funeral Service Holloway Funeral Home P.A. 7626 R 501 Snow Hill Rd. Salisbury, Maryland 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cancer hung /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the Hospitel or Attending Physician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ COPI 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Be Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA After this the funeral 28c. Injury at Work? Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, tactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospitel or Att within 24 hours after d To the Funerel Direct 4 Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 029105 Graduto 0 106 Milford St, SAlis, MD 21804 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Huddleston, MI ChRISTION 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Unnewehr 19, 10:13 AM Lewis **Emory** 2009 May 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Annapolis Anne Arundel Medical Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 270-20-4443 Ohio 9/27/1925 83 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2x No Bowie Prince George's MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20716 3800 Enfield Chase Court Apt. #205 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Automotive Electrical Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ivy May Lewis Emory Carl Unnewehr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3800 Enfield Chase Court, Apt. #205, Bowie, MD 20716 Laurel Jean Unnewehr/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/21/2009 Baltimore, Maryland Bayview Crematory 4 ☐ Donation 15 ☐ Other (Specify) 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ascending disease or condition resulting in death) Due to (or as a consequen of) Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy Month Day Year 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 26. Place of Death Check onl one

Physician /Medical xaminer

**Physician** 

/Medical

Examiner

Funeral

Director

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It is marked other than "r traumatic event, the Med

permit. Pages 1 and 2 should be fil.
Department of Health and Mental H.
Important: If Item 27 is marked oth
any injury or other traumatic even

the Medical

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division or Vital Records,

Director

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certificate be exect e Hospital or Attending Pil 24 hours after death.
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Registrar

Sequentially list conditions, if any, leading to immediate caus. Lines of Johnson Cause (Disease or injury that initiated events resulting in death) Last Examiner IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 → Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number

Rea, MD.

D61829

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 Medical Poskury Annapoli, MD

Lee-Llacer I, M.D. Reynaldo 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar John

31. Date filed (Month, Day, Year)

Ma

509 Idlewild

MD

32. Registrar's Signature

rea

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Year 2009 02:30 PM 20 George Ben\_Whited May 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Cecil 931 Mechanics Valley Road North East 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Days Hours 1**1** M 2 □ F 221-09-1997 May 21, 1911 Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Ceci1 North East 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21901 United States 931 Mechanics Valley Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2√ No Specify. Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator <u>Manufacturing</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Thomas Whited Louisa Plaster 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Completed Be

Director

Funeral

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**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

d other than "natural", or items 23a or 28a-f sho

nd Mental Hygiene. marked other than

Pages 1 and 2 s ment of Health ar Health am 27 i

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	Bill Whited / Son		931 Mecha	anics Val	ley Roa	d, North I	East, M	lary1and2190
	20a. Method of Disposition  1 → Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State No E	lace of Disposition (Pemetery, crematory of th East Me emetery	lame of or other place) ethodist	May 25 2009	,	eation - City or	Town, State  Maryland
	21. Sign to be Funeral ervice under		22. Name	and Address of Fac		h Funeral , North Ea		ry1and21901
	23a. Part 1. Enter the disease, or come shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	olications that caused the death one cause on each line.  a. Due to ras a consequ	Heart fa	node of dying, such	as cardiac or re	espiratory arrest,		Approximate Interval Between Onset and Death
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Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1	death 3 Ectopi	c pregnancy (specify)			3d. Date of de Month	ilivery Day Year
	Part II. Other significant conditions of	ontributing to death but not resu	lting in the underlyin	g cause given in Par	t I.		4	o the cause of death?
Completed by						24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No	prior to death?	utopsy findings available completion of cause of s 2 1 No
Be	25. Was case referred to medical examiner?				ce of Death (C	heck only one)		
	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 🗆	Nursing Home	5 Residence 6	☐Other (Spε	ecify)
Certification: To	27. Manner of Death  Natural 5 Pending  Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2		. Describe how injury	occurred	
Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, fact	ory, office	28f.	Location (Street and City or Town, State)	i Number or R	ural Route Number,
Medical		ysician: To the best of my know niner: On the basis of examinat and manner stated.						
Ž	29b. Signature and title of certifier	Relia		29c. License numbe	4903	29d. Date	e signed (Mont	th, Day, Year)
	30. Name and address of person who of		23a) (Type, Print)	East.	MDO	11901	Pamel	le Leelant

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State Registrar 31. Date filed (Month, Day, Year)

			For State State State State State State State Registrar	•	tificate of			eg. No 2 0 0 9	18882
	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month <b>MAY</b>	Day Year <b>2009</b>	3. Time of Death  9:45 A M
-	/Medic Examin		MARJORIE ANN WILLIAMS  4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	FIAI	4c. County of Dea	
4500	LXaiiiii		304 QUEEN ANNE CIRCLE DRIVE, AN	PT.D-1	CENTRE			QUEEN AN	
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ▼ F 7. Age (In yrs. 71	last birthday) _ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, OCT.13,	9. Bir Co 1937 MAS	thplace (State or Foreign buntry) SACHUSETTS
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980	within 72 hours after death with the Maryland iten than "natural", or items 23a or 28a-f show item "dicel Exerting the motified at	by	Armed Forces?  1 □ Never Married 2 □ Married  3 □ Widowed 4 ▼ Divorced  Armed Forces?  1 □ Yes 2 ♠ No If Yes, Give Year or Dates:		□Yes 2 <b>X</b> No	Specify:	, , , , ,		HITE
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Maryland	2 sho and is me is me	ľ	19a. Informant's Name/Relationship (Type. Print)	'	•			r, City or Town, State,	Zip Code)
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Medical Example in usib be notified at once.		1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State CHI	cemetery, crem ESAPEAK	natory or other place  E CREMAT	e) MAY 2	28,2009	STEVENSVII	•
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o O	Physician: The law requires that the death ce this certificate has been signed by the attending director, page 2 should be detached for use	Physician/	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of 0	death 5	Other (specify) _			Mondi	54,
σ.	s that the de ned by the e detached		Part II. Other significant conditions contributing to death but not res	ulting in the un	nderlying cause giv	en in Part I.	23e. Did tol	bacco use contribute t	o the cause of death?
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<u>5</u>	Physic this or		1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐			4 Li Nursing Ho		ence 6 ☐ Other (Spe	acify)
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Division of Vital	Attending or death. ector: After by the fune.	ficat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At h.	ome, farm, stre		res 2 livo	28f. Location (S	treet and Number or R	ural Route Number,
2	al or safter	Certification: To	4 ☐ Homicide determined building, etc. (Special	(y)			City or Town		
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	5		Value pro Dio De	Macai	Н0057	821		MAY 27,	2009
	NS		30. Name and address of person who completed cause of death (Iter DR. VALERIE GOODMAN, D.O., 254			RN CENTO	EVILLE	MD 21617	
	Sta	te.	31. Date filed (Month, Day, Year)  32. Registrar's Signa		. VE V ILLE	KD, CENIK	و ظلالتا ۷ ت	FID ZIVII	
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	/Medic Examin		4a. Facility Name (If not institution	, give street and number)			4b. City, Town, or	Location of De	ath	4	c. County of Death	
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altimore,	Pages nent of ant: If its arry or o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)	3 ☐ Removal from State	ceme	etery, cřen	natory`or other plac Crematory	· .	27/2009	l <sub>Ba</sub>	ltimore,	MD
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	Physician /Medical Examiner	7 17	23a. Part 1. Enter the disease, or shock, or heart fature. List Immediate Cause (Final disease or condition resulting in death)	only one cause on each li	a consequence	a,	er the mode of dyir	sy van	diac or respiratory	arrest,	rempring	Approximate Interval Between Onset and Death
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	ate be executed ysician and ne burial-transit	ical Examiner	that initiated events resulting in death) Last	cDue to (or as	a consequenc	ce of):						
P.O. Box 68	Physician: The law requires that the death certificate be this certificate has been signed by the attending physicianal director, page 2 should be detached for use as the bur	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal dea	ath 3□	Ectopic pregnanc	у		-	23d. Date of delive Month	ory Day Year
rds, F	quires that an signed t uld be det	þ	Part II. Other significant condition	ons contributing to death b	out not resulting	g in the ur	nderlying cause giv	en in Part I.			o use contribute to th	
l Reco	sician: The law re s certificate has bee irector, page 2 sho	Completed						· · · · · · · · · · · · · · · · · · ·	24a. W — au pe 1 ∐ Ye:	topsy rformed?	prior to cor death?	psy findings available inpletion of cause of
/ita	cian: ertific ector,	Be (	25. Was case referred to medical examiner?				Tou.		Death (Check onl			
of	Physic rthis c		1 Yes 2 No 27. Manner of Death	Hospital: 1  Inpati	ient 2 ER/	Outpatier  b. Time of		4 LI Nursin			6 ☐ Other (Specify	y)
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director. After this certific completely filled in by the funeral director,	Certification: To	1 Natural 5 Pendin 2 Accident investig 3 Suicide 6 Could of determ	g (Month, Da gation not be 28e. Place of In	ay, Year)	Injury	Wor	k? Yes 2 □ No	28f. Location	n (Street	and Number or Rura	l Route Number,
Ö	pital or ours afte eral Dir filled in			ng Physician: To the best		dae dest	a aggurred at the ti	ma data and al	4	rown, Sta		tated
;	To the hospital or within 24 hours afte To the Funeral Dir. completely filled in I	Medical	(Check only Medical one)  29b. Signature and title of certifier	Examiner: On the basis of and manner st	of examination	and/or in	vestigation, in my o	ppinion, death o	ccurred at the tin	ne, date a	and place, and due to  Date signed (Month, )	the cause(s)
	F 3 F 8	اور	TAN Cha	& John Je	ten	M	a D	214	138	N	lay 2	6,2009
	1/22	1.5	30 Name and address of person	the complited cause of CANTA	441		ELENZE	176	HWAY !	Two	JAPOLIS W	D2149
	Sta Registr		31. Date filed (Month, Day, Year)	2009 Seken	rar's Signature	40	wed					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 3:05<sup>P M</sup> William Wellington May 26, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 5260 Daventry Terrace Forestville Prince Georges If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 🔀 M 2 🗆 F Yrs. Director 245-64-8674 Nov. 10, 1942 Wayne Co., NC 66 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show or than "natural", or items 23a or 28a-f shov Director 1√Yes 2 No Maryland Prince George's <u>Forestville</u> 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5260 Daventry Terr. 20747 2 should be filed within 72 hours after death v and Mental Hygiene. is marked other than "natural", or items 23 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ∐Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electronic Technician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be ealth and Mental permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev William Wellington Sr. Rosa Lee Barnes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Wellington / Wife 5360 Daventry Terr. Forestville, Maryland 20747 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan 6/1/2009 Alexandria, VA 21. Signature of Funeral Service Lice 22. Name and Address of Facility
Alexander S. Pope. Pr.A.
5538 Mariboro Pike/Prorestville, Md. Addition of the complication of the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, tonly one cause on each line. 20747 23a. Pa 1. In e the disease shock, or heart failure. L Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Heart **Physician** ongestive /Medical Due to (or as a sinsequence of): Examiner andie Myopathu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed aronary Artera attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 ☐ Other (specify) 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has t , page 2 s autopsy perform certificate 2 No 1 ☐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ∐ Yes 2 🛣 No Other: 4 ☐ Nursing Home 5 M Residence 6 ☐ Other (Specify) After this of funeral dire 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 124 hours after death.

le Funeral Director: A
bletely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

To the Hosp within 24 hou To the Funer completely fi

Box 68760

P.0.

Division of Vital Records,

State Registrar

Medical

29a. Certifier

NOUYEN 31. Date filed (Month, Day MAY 2 9 2009



and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D0058686

29d. Date signed (Month, Day, Year)

BRANCH AVENUE TEMPLE HILLS, MD 20748

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month\_ 155PM **Physician** 2009 William Ray Wiskman /Medical or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Min Months 1 X M 2 □ F Director 213-30-3789 Nov. 30, 1931 Indiana Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 ☐ Yes 2 No Director MDWicomico Salisbury 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21801 U.S.A. 7865 Bennett Park Drive Funeral 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? 1 XIYes 2 □ No 1952-Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify: Specify: Completed by 3 Widowed 4 Divorced 1955 white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 2121 College (1-4or 5+) Elementary/Secondary (0-12) Department of Defense Lieutenant 18. Mother's Name (First, Middle, Maiden Surname) **3altimore, Maryland** 17. Father's Name (First, Middle, Last) Be and 2 should be f lealth and Mental Harold Wiskman Carrie Reeder ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21801 7865 Bennett Park Drive Salisbury, MD Ellen R. Champion (Wife) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Pages 1 ment of F May 27, 2009 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Important; If any injury or once, **Jepartπen**l 4 ☐ Donation 5 ☐ Other (Specify) Eastern Shore Veterans (Cem. Hurlock, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home 13 East Grove Street Delmar, DE 19940 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final BRAIN CARCINDUM **Physician** MAHENANT disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, and the sequence of the sequence Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) been signed by the sahould be detached to 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy 1 ☐Yes ÆNo To the Funeral Director: After this certificate completely filled in by the funeral director, pag or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Cother (Specify) HOSPICA Hospital: 1 Yes 25 <del>111</del>6 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred + ■ Natural 5 ☐ Pending investigation after death. 1 ☐ Yes 2 ☐ No √2 □ Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2005 8410

Registrar

State

HOSPICIZ

egistrar's Signature

POBOX1737 SKUBBURYOUS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

COASTAL

32.

WARY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend PIT & 25, per ME 8895 9/10/09 TI State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** William Whitney 2009 1200 May /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner NICOMICO 59/15649 Keg 10NOS TENINSULA as ice If Under 1 Year | If Under 24 Hrs/ Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Min 1**⊠** M 2□ F Months Days Hours MD 1/29/27 Director 82 213-24-4625 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10h County 28a-f show traumatic event, the Medical Examination nust be positived at M∏Yes 2 ☐ No Director Wicomico MD Salisbury the ! 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö death with 23a U.S.A. 200 Sarah Lane 21801 Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" -- nany injury or other traumatic excessions. items 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1X Never Married 2 ☐ Married 1 ☐Yes 2 🛛 No Specify: þ 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Allen Perdue Farmer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bernadine Polk ဂ္ဂ Edward Whitney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 624 Townsend St, Wilmington, DE Magnolia Jones/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Direct Cremation 5/29/2009 Dover, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fur eral Service Licensee 22. Name and Address of Facility 917 W.Isabella Bennie Smith Fun Home Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause and on line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or a a consequence of): Examiner neumas Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINER Examiner Due to (or as a consequence of): burial-tran and requires that the death certificate be exect Due to (or as a consequence of): P.O. Box 68760, iis certificate has been signed by the attending physician director, page 2 should be detached for use as the burial Physician/Medical IF FEMALE yes, outcome of pregnancy □ Live birth 2 □ Fetal death □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No this certificate 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes -2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral c 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Pl 24 hours after death. Funeral Director: After the After t 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. To the I within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifit 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salisbury M& 21801 arroll St FFre 10 reland m, D 100 32. Degistrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

MAY 26

			1- For Amend Items 25,27,28a-f per me,g	partment of Health and I 897, 11/19/09dhb	Mental Hyg	jiene <sub>eg. No</sub> 2009	18887	
			Registrar  1. Decedent's Name (First, Middle, Last)		2. Date of Deat	th	3. Time of Death	
	Physicia	an	Regina M. Zanelotti	May 21,	2009 Year	7:38 PM		
-	/Medic Examin		4a. Facility Name (If not institution, give street and number)	1	4c. County of Death			
	Examin	er	Anne Arundel Medical Center		Anne Aru	ndel		
	Funeral	_	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Annapolis y) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth (Month, Day		place (State or Foreign	
	Director		213-46-9958 1 M 2 TXF 62 Yrs.	Months Days Hours Min.	Nov. 23	3, 1946 Wash	ington, D.C	
	p.		Usual Residence of Decedent				Od India Ob Link	
	arylaı <b>shov</b>	<u>-</u>	10a. State 10b. County 10c. City, Town or	Location		1	0d. Inside City Limits  1XXYes 2 □ No	
	Ba-f	Director	MD Prince George's Bowie					
	with th	ڃَ	10e. Street and Number	10f. Zip Code 20715	1	0g. Citizen of What Coul USA	ntry?	
	filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or items 23a or 28a-f show ent, It e Medicel Exeminer must be redified at	eral	13515 Youngwood Turn  11 Marital Status   12. Was Decedent Ever in U.S.   13		nocify Vos or No	14. Race - Americ	can Indian	
	item item	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No	<ol> <li>Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert</li> </ol>	o Rican, etc.)	Black, White,		
36	rs af	by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐Yes 2 ☒No Specify:		Specify:	White	
21215-0036	2 hou	ted	15. Decedent's Education 16a. De	cedent's Usual Occupation		16b. Kind of Business/In		
218	hin 7:	ple	(Specify only highest grade completed) (Gi	ve kind of work done during most of wor . DO NOT use retired)	rking			
2	d wit gien ger th	Completed	12	Title		Real Estate	<u> </u>	
p	be file	Be (	17. Father's Name (First, Middle, Last)		ne (First, Middle, I			
yla	Men Men arke	၉	John L. Zanelotti, Sr.	Josep	ohine G.	Bisaccia		
lar	2 sho n and is m raum			iling Address (Street and Number or Ru			o Code)	
e o`	and Health m 27			5 Youngwood Turn	Bowie,		num State	
9	ges 1 It of 1- If ite or ot		20a. Method of Disposition 20b. Place of Discornetery, c 1 ☐ Burial 2 又Cremation 3 ☐ Removal from State	position (Name of ematory or other place)	Date	20c. Location - City or To	own, State	
턡	t. Pa tmen tant: jury		4□Donation 5□Other (Specify) Bayview			Baltimore, M	1D	
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It e Modical Examiner must be redified at once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Be	eall Fune	eral Home		
_	TD = #0 04	10 P	Verst	6512 NW Crain Hwy.				
			23a. Part1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.			est,	Approximate Interval Between Onset and Death	
-6	Physician		Immediate Cause (Final disease or condition resulting in death)	embolism				
	/Medical Examiner		Due to (or as a consequence f):	1/ 1-00		V 02 7 1000		
		<u>-</u>	Se wentially list conditions if any leading to immediate b. Due to (or as a consequence of):	embolism thrombosi	<u>ح</u> ج .	1//		
Т	uted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	_	•4	DICALEXAMINER		
<u>,</u>	be executed sician and burial-transit	Еха	that initiated events resulting in death) Last c. Due to (or as a consequence of):	$\mathcal{J}$	- NAROVED BY	MLD		
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89	eath certifical attending phy for use as th							
Вох	th cer endir	Physician/Med	IF FEMALE: 23b. Was decedent pregnant   1	B   Ectopic pregnancy		23d. Date of deliv		
	deal	sicie	1 Yes 2 No 4 Pregnant at time of death	5 ☐ Other (specify)		Month	Day Year	
<u>Ч</u>	at the de 1 by the stached	hy	9 LI Unknown		I			
Ś	es th igned	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		bacco use contribute to t	/	
Records,	requil een s rould	Completed	morbid oberity.		1 🗆 Y	es 2 □ No 3 □ Pro	Dabiy 4 Unknown	
ec	law las b	ple	paraplegia.		24a. Was a autops	sy prior to co	opsy findings available ompletion of cause of	
	: The	Cou		perform 1 □ Yes	performed? death?  ☐Yes 2☐No 1☐Yes 2☐No			
Ϊŝ	siclan: The law certificate has birector, page 2 s	Be	25. Was case referred to medical examiner?		ath (Check only or	ne)		
1	this c	ပ္	1 Yes Hospital: 1 Impatient 2 ☐ ER/Outpat		Υ	ence 6 Other (Speci	ify)	
Ĕ	ing F	ion:	27. Manner of Death  28a. Date of Injury (Month, Day, Year)  Investigation (Month, Day, Year)  Unknown	of 28c. Injury at Work?  1 □ Yes 2 ☒ No	Subject	ow injury occurred <b>passenger</b> i	in a car	
S	ttenc death stor: the	icat	2 Accident Investigation 11ay 031304	p.		verturned	ni Pouta Number	
Division of Vital	or A after Direction by	Certification: To	4 Homicide determined building, etc. (Specify)			treet and Number or Rur n, State) <b>Prince</b>	George's	
			Roadway  29a. Certifier 12 CertifyIng Physician: To the best of my knowledge, de		County, e. and due to the		stated.	
	To the Hosp within 24 hor To the Fune completely fi	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or one) and manner stated.					
	To th	Me	29b. Signature and title of certifier	29c. License number	2	29d. Date signed (Month,	Day, Year)	
	0		> Shiph(Ver one	D58510	0	05/21	109	
	38V		30. Name and address of person who completed clause of death (Item 23a) (Typ	e, Print)			21401	
	11/2		Stephen Olexa	DS8510 e, Print) AAMC 201	DI Medic	al Kluy Ah	naplis mo	
	Sta		31. Date filed (Month, Day, Year) 32 Registrar's Signature				1 -1	
	Registra	ar	MAY 27 2009 Leture S. A.	arke				

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Month 615 AM Raymond C. Angeletti 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death AGNES BALTI MORU If Under 1 Year | If Under 24 Hrs. HOSPITAL 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs. Birthplace (State or Foreign Country) 1 M 2 □ F Months Days Hours 215-42-6454 AUG 31, 65 1943 Maryland Usual Residence of Decedent 10b. Count 10c. City, Town or Location 10d. Inside City Limits **Baltimore** Catonsville 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 55 Wade Avenue 21228 USA Was Deceus. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 X No Specify: Specify: 3 Widowed 4 N Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cobbler Shoe Repair 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Primo Angeletti Murrel1 Goodlett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rodney C. Angeletti, son 407 Wilgis Road Fallston, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory, Inc. 06/12/09 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee George MacNabh Cremation Society of MD, Inc. E Man 299 Frederick Road Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Imonany disease or condition resulting in death) days Due to (or as a consequence of): Thrombes unknown Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence off: Not mobilizano resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Distase 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a, Was an 1 TYes 2 NO 26. Place of Death (Check only one)

**Physician** /Medical Examiner Examiner

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

Completed

Be

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**Funeral** 

Director

show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, it. "Ledical Examine from the permitted and the control of the co

Saltimore, Maryland 21215-0036

death certificate be executed burial-1 physician a attending p been signed by the should be detached

has N page certificate

After this funeral death. filled in by the within 24 hours after deatl To the Funeral Director:

Division of Vital Records,

Physiclan:

or Attending

To the Hospital

Physician/Medical Completed by Be Certification: To

Medical

25. Was case referred to medical examiner? 1 Yes 2 No

29a. Certifier

(Check only one)

27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide

5 Pending investigation 6 ☐ Could not be determined

Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28d. Describe how injury occurred

29b. Signature and title

and manner stated.

29d. Date signed (Month, Day, Year) 2009

d address of person who completed cause of death (Item 23a) (Type, Print)

Natalie 900 Caten Avenue 31. Date filed (Month, Day, Year)

State Registrar

completely

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #5, SperFH 9893 7/13/09 TT

Amend Property 
			For State Registrar	end #3,Si	ate of M	ařýlánó	-	írtmen <i>tificat</i>				giene Reg. No.	0000	18889	
	Physici	an	1. Decedent's Name (First	, Middle, Last)							2. Date of De Month	ath Day	Year	3. Time of Death	
	/Medic		JANET L.								JUNE	-	2009	11:10 A.M	
3	Examin	er	4a. Facility Name (If not in: 307 LINDEN		t and number,	)		4b. City, Town, or Location of Death TOWSON			:n	4c. Co		County of Death BALTIMORE	
op*	Funeral		5. Social Security Number <b>079–38–939</b>		7. Ag	ge (In yrs. la	ast birthday)	If Under	1 Year	If Under 24 Hrs	8. Date of Bi	th	9 Bir	thnlace (State or Foreign	
	Director		0/9-38-939	1 □ M	2 <b>∏</b> F	93	Yrs.	Months	Days	Hours Min	8. Date of Bir (Month, D. 11/17/	1915	NE	W YOK	
	pu »		Usual Residence of Deced	ent County		I 100 City	, Town or Loc	ation						10d. Inside City Limits	
	f sho	5		PUTNAM			HOPAC	ation						1 □Yes 2 □No	
-	the N	rect	10e. Street and Number	CINAM		PIPA	HOPAC	10f, Zip	Code			10g. Citi	zen of What Co		
	3a or	<u>=</u>	11 ARCHER RO	OAD						10541			USA		
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, I'm Madical Everine, must be notified a	Funeral Director	11. Marital Status	12. V	Vas Decedent		i. 13. V	Vas Deced			Specify Yes or No to Rican, etc.)	)-	14. Race - Ame Black, Whit		
20	or it	by Fu	1 Never Married 2	Married 1	☐Yes 2☐ Yes, Give	X <sub>10</sub>		☐Yes 2		Specify:	to rindari, oto.,			HITE	
2-003b	hours tural"		3 ₩ Widowed 4 □ Di	vorced Y	ear or Dates:		16a. Deced			ation		16h K	nd of Business		
Ċ	n /2 n "nai	plet	(Specify only	ecedent's Educatio highest grade cor	npleted)	- >	(Give F	aind of wor ONOT us	rk done a se retired	luring most of wo )	rking	100. KI	ild of business.	muustry	
717	giene giene rrtha	Completed	Elementary/Secondary ( 12TH GRADE	0-12)	College (1-4or	5+)		EMAKE				0	WN HOME	,	
land	s 1 and 2 should be belied within 72 hours after death with the Marylan if Health and Mental Hygiene. If the 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, "in Madical Expriner must be notified at	Be	17. Father's Name (First, I	Middle, Last)						18. Mother's Na	me (First, Middle	, Maiden	Surname)		
y y a	should be t and Mental I s marked of umatic eve	2	WTILTAM LEA	DRETTER						NEE	LY BARGE	R			
Mar	2 Sh h and rism raum		19a. informant's Name/Re	elationship (Type. F	Print)		19b. Mailin	g Address	(Street a	and Number or F	ural Route Numb	er, City o	r Town, State,	Zip Code)	
ė,	Tand Health em 27 ther t	1 3	NANCY_HARVI 20a. Method of Disposition		TER	20b Pl:	307 I	INDE	N AV	ENUE TO	DWSON, M		<b>1286</b> cation - City or	Town State	
2	ages ant of t: If it		1 XBurial 2 ☐ Cren	nation 3 🗆 Remo	val from State	BALL	ace of Dispos metery, crem ARD-BA	ARRET	ther place T CE	'M'			PAC FAL		
Бантіто	permit. Pages 1 and 2 sn Department of Health and Important: If Item 27 is m any injury or other traum once.	1 3	4 ☐ Donation 5 ☐ O		, MO	1139				1 9/1	2/2009 F JOHNS			HOME, P.A.	
מ	Dep Jan A	Z Y	Heath	Hall +1	nusin		1				LVD. TY			21286	
			23a Part 1. Enter the dise shock, or heart failur	ase, or complication	ons that cause	d the death.							, 1.11	Approximate Interval Between	
P	hysician	ΥÍ	Immediate Cause (Final disease or condition	or Elot orny one od	Deb		4							Onset and Death	
	/Medical Examiner		resulting in death)	( a	Due to (or as		ence of):								
٠	.xammei	<u></u>	Sequentially list conditions if any, leading to immediat	s, b		CVD									
700	nsit	nine	Cause (Disease or injury	•	Due to (or as	a conseque	ence ot):								
6	n and al-tra	Examiner	that initiated events resulting in death) Last	с	Due to (or as	a conseque	ence of):								
700,	ysicia le buri	edical		d											
00	ng ph as th	Medi	IF FEMALE:												
XOD E	ttendi	Physician/M	23b. Was decedent pregna	ant	f yes, outcome    Live birth	2 🗌 Fetal	death 3	Ectopic p	regnancy	,			23d. Date of de Month	olivery Day Year	
5	the a	sic	in the past 12 months 1 ☐ Yes 2 Mo 9 ☐ Unknown	9	F□ Pregnant a F□ Unknown	at time of de	eath 5	Other (sp	ecify)				month	Day 10a.	
7. ±	ed by detac		Part II. Other significant of	onditions contribu	iting to death b	out not resul	ting in the un	derlying ca	ause give	en in Part I.	23e. Did	tobacco ι	use contribute t	o the cause of death?	
SD	n sign	d by	Seizu	re D	isoral	er					1 🗆	Yes 2	<b>x</b> 000 3□ F	robably 4 Unknown	
ecords,	s bee	lete									24a. Was	an	24b. Were a	utopsy findings available	
ב ב	to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affe death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed										psy prmed? 2 No	prior to death?	completion of cause of s 2 □ No	
בו בו	ertifica etor, p	Be C	25. Was case referred to n	nedical						26. Place of De	1 ☐ Yes ath (Check only	one)	= Constelligat		
2 - Presis - C	his ce	TO E	examiner? 1 Yes 2 No	Hospi	tal: 1 ☐ Inpati	ient 2 □ E	R/Outpatient	3 □ DC	Othe	er: 4 🗆 Nursing	Home 5 ☐ Res	idence	OAUGHTE 6 DOther (Sp.	R'S RESIDENC	
	After i	iuo.		Pending	Ba. Date of Injudently (Month, Da	ury ay, Year)	28b. Time of Injury		8c. Injury Work		28d. Describe	how injur	y occurred		
VISION	death	icat	3 ☐ Suicide 6 ☐	investigation  Could not be	Po Place of In	iury . At hor	no form stro	M		res 2 □No	29f Location	Ctroot on	d Alembaras E	Pural Pauta Number	
	after Direct	Certification:	4 Homicide	determined 2	Be. Place of In building, e	tc. (Specify)	)	et, lactory	, onice		City or To	wn, State	)	lural Route Number,	
- chira	hours hours ineral y filler		29a. Certifier	ertifying Physicia	n: To the best	of my know	vledge, death	occurred	at the tin	ne, date and plac	e, and due to the	e cause(s	) and manner a	as stated.	
H of	in 24 he Fu	edical	(Check only /2 M	edicał Examiner:	On the basis of and manner st	of examinati tated.	ion and/or inv	estigation	, in my o	pinion, death occ	urred at the time				
Ę	To Too	Σ	29b. Signature and title of	certifier		na		290		number			te signed (Mon		
			DA	occos		m)			D	40048		6	6-9-0		
-			30. Name and address of p	oerson who comple	eted cause of $\mathcal{D}_{\mathcal{R}}$	death (Item	23a) (Type, F		V	mD	21	200	1		
	Sta	te	31. Date filed (Month, Day,	Year)	32. Regist	rar's Signatu	ure					/			
	Registr		JUN 1 2	2009 2	me	A	to all								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month JUNE Dey 1 2 , 2 2 1219 Theresa W. **Physician** Antiporowich 06:51AM /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4c. County of Death Examiner Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🗓 F 218-26-6830 82 Sept. 9,1926 Maryland Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evarance must be notified at once. 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2X No Director Maryland Baltimore Rosedale 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9523 Shirewood Court 21237 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes ŽŽNo Baltimore, Maryland 21215-0036 Specify: White Yes. Give Specify: \$ 3 Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 8 Years College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gustav Ellinger Anna Bushmeyer 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14213 Pleasant View Drive Mr. Bruce Antiporwich (Son) Bowie, MD 20720 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 6/13/2009 Elkridge, MD 4 ☐ Donation \_5 ☐ Other (Specify) Holy Trinity Russian 21. Signature of Juneral Service Licensee Orthodoz. NG mantable ys of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the 3 ease, or conshock, or hear filtre. List fly plications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, ly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ENCEPHALOPATHY ANOXIC disease or condition resulting in death) /Medical Examiner CARDIO-RESPIRATORY ARREST Esquentiam liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner be executed attending physician and for use as the burial-transit ACUTE MYOCARDIAL INFARCTION resulting in death) Last Due to (or as a consequence of) Box 68760, CORONARY ARTERY DISEASE Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) P.0. this certificate has been signed by the all director, page 2 should be detached 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 4 X nknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1□Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28d. Describe how injury occurred After 1 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) W 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D31826 6-10-09 Mithicum varct 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOWSON, MARYLAND 21204 7601 OSLER DRIVE RICHARD LINTHICUM, M. D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 1 2 2009 racket Registrar

DHMH 17 Rev 1/2001

Pages 1 and 2 should be filed within 72 hours after altimore, Maryland 21215-0036

burial-tra Box 68760, aftending physician for use as the buria P.O. cate has been signed page 2 should be det Records, Division of Vital funeral director, To the Hospital or Attending I within 24 hours after death. To the Funeral Director; After filled in by the

State of Maryland / Department of Health and Mental Hygiene
1- State Amend Items 25,27,28a-f per me 892,06/11/09dhb
Reg. No.
Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death 2009 **Physician** 26, 10:34 A M MAURICE Α. BLOUNT MAY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES FT. WASHINGTON HOSPITAL FT. WASHINGTON if Under 1 Year | if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1<del>√</del> M 2□ F Months Days Hours 15 577-25-4718 Yrs. Director Sept.10,1993 Washington, D.C. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ms 23a or 28a-f shov 1√2 Yes 2 □ No Director Maryland Prince Georges Ft. Washington 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? United States 20744 403 Bentwood Dr. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♣ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married ٥ 1 ☐ Yes 2 🔼 No Specify: Specify: Black þ 3 Widowed 4 Divorced "naturai" Completed th and Mental Hygiene.
7 is marked other than "natul traumatic event, the World's 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Şecondary (0-12) N/A Student 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Veda Blount Shawn Lee မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20744 403 Bentwood Dr. Ft. Washington, Md. other t Veda Blount / Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If Ite any Injury or otl 1 
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Heritage 6/3/2009 Waldorf, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Alexander S. Pope P.A. 5538 Marlboro Pike/Prorestville, Md. 20747 aug MOIOS Part 1. Inter the diseas a police of that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, if heart failure. It only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (fr is a consequence of): disease or condition resulting in death) /Medical **Examiner** brain Sequentially list conditions, if any, leading to infine late cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine CERTIFICATION APPROVED BY Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) aminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Accident 5 Pending Subject pedestrian struck by a car. 1 □Yes 2 X No investigation Unknown Unknown <sup>M</sup> 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Unknown Unknown 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 0005311 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. PATRICK DALY, MD. 11711 LIVINGSTON ROAD, FT. WASHINGTON, MARYLAND 20744-5164 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 4c per dr.,8895,09/29/09dhb.

State of Maryland / Department of Health and Mental Hygiene

1- State Amend Items 25,27,28a-f per me, 2892,06/11/09dhb

Reg. No. 2 0 0 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Year Month Day **Physician** : 40 PM Becker Mai Caymond 2009 ar 9 /Medical 4b. City, Town, or Locetion of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Carroll Hospital Center Carroll Westminster If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1√2 M 2 □ F Hours Yrs. 80 220-20-2845 Oct\_ **Director** 31 1928 MD Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination to other traumatic event, the Medical Examination or other traumatic event, the Medical Examination of the Medical Examination 1 ☐ Yes 2 ☐ Wo Director MD Carroll Sykesville 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 5930 Grace Lee Avenue 21784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Korea If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Department of Navy marine engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward A. Becker Margaret Startt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5930 Grace Lee Ave., Sykesville, MD 21784 Janice T. Becker (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-22**-**09 Sykesville, MD Lake View Memorial 22. Name and Address of FacilityHaight Funeral Home & Chapel 21. Signature of Funeral Service License Parge House there & P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a Multiple organ system tailure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner sternic inflammatory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner CERTIFY THON APPROVED BY MEDICAL EXAMINER physician and s the burial-trans Due to (or as consequence of): that initiated events resulting in death) Last P.O. Box 68760, Physician/Medical propic attending p use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Year 1 □ Yes 2 □ No. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Récords, þ Hypertension, Hyperlipidemia 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed New onset atrial fibrillation, Were autopsy findings available prior to completion of cause of death? certificate has b irector, page 2 sh 25. Was case referred to medical examiner? performed Yes 2 No 1 ☐ Yes 2 ☐ No hand suraical repair. Anemia chronic director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After th funeral 28a. Date of Injury (Month. Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending 05/13/2009 Unknown M Subject fell 2 Accident 3 Suicide investigation 1 ☐ Yes 2 X No within 24 hours after death

To the Funeral Director: , 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5930 Grace Lee Ave. Sykesville, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Home To the Hospital 29a. Certifier 1 🙀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 028462 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carrell Hospital Westminster Maryland 21157 MO Boston 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar JUN 1 2 2009

DHMH 17 Rev 1/2001

State Registrar 29b. Signature and title

KICHARD

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

JUN 1 2 2009

Box 68760,

P.0.

Division of Vital Records.

TOWERS

CRATU

Registrar's Signatu

29c. License number

DOZ519

GLEN BURNIE

29d. Date signed (Month, Day, Year)

			1 - State Of IVIA		artment of Health and N <i>rtificate of Death</i>		2009 18894
	Physici		1. Decedent's Name (First, Middle, Last)  Joseph Thomas Biden			2. Date of Death Month June	7, 2009 3. Time of Death 11:58 P M
	/Medio Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
	Funeral			(In yrs. last birthday)	Halethorpe If Under 1 Year If Under 24 Hrs.		Baltimore  9. Birthplace (State or Foreign
	Director		213-05-2403 1 ♣ M 2 ☐ F 9	8 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, 19	9. Birthplace (State or Foreign Country) MD
	ryland show	_	10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limits
	the Ma	ecto	MD Baltimore  10e. Street and Number	Haletho	rpe 10f. Zip Code	100	1 ☐ Yes 2 No
	th with 23a or	al Dii	1232 Circle Drive		21227	109	USA
36	hours after death with the Maryland tural", or items 23a or 28a-f show N.Examinat be molified at	y Funeral Director	11. Marital Status  1 Never Married 2 Married  12. Was Decedent E Armed Forces?  1 Yes 2 Married  17 Yes 2 Married	0	Mas Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto □ □ Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: T.Tb.; + 0
Maryland 21215-0036	e filed within 72 hours al Hygiene. other than "natural", vent, I've Medien Exa	Completed by	3 X Widowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education (Specify only highest grade completed)	16a, Dece	dent's Usual Occupation	16	b. Kind of Business/Industry
121	within 7, iene. than "n	mple	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5-	-)	kind of work done during most of work DO NOT use retired)	ing	Ei nama a
1d 2	filed v Il Hygie other i	Be Co	17. Father's Name (First, Middle, Last)	Cred	it Manager 18. Mother's Name	e (First, Middle, Ma	Finance  iden Surname)
ylar	ould be f Mental larked o	To B	George T. Biden		Annie Na	arer	
	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, I'm Medical once.		19a. Informant's Name/Relationship (Type. Print) Robert J. Biden/son	1232	g Address (Street and Number or Run Circle Drive Hale		
Baltimore,	Pages 1 lent of H nt: If iter ry or oth		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)		sition (Name of natory or other place)  Crematory  6-9-2		c. Location - City or Town, State  en Burnie, MD
Balti	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee	22	. Name and Address of Facility Ambr	cose Fune	
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	the death. Do not ente			t, Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Ke			Onset and Death
7	Examiner			consequence of):			
	ted nsit	niner	cause. Enter Underlying	consequence of):			
Sequentially list contourns, if any, leading to immediate cause. Enter Underlying Cause (Diseas or figure that initiated events resulting in death) Last  Due to (or as a consequence of):							
68760,	icate be physici the bu	edical	d				
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome 0 1 □ Live birth 2 4 □ Pregnant at 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
S, P.	ires that signed b	þ	Part II. Other significant conditions contributing to death bu	t not resulting in the ur	derlying cause given in Part I.		cco use contribute to the cause of death?
Records,	w requir been s should I	leted				1 Li Yes 24a. Was an	2 No 3 Probably 4 Unknown  24b. Were autopsy findings available
_	hysician; The law his certificate has I director, page 2 s	Completed				autopsy performe	prior to completion of cause of
Vital	s certifi	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatier	nt 2 ☐ ER/Outpatien	Othor	h (Check only one)	0 F101
n of	ding Phy h. After this funeral c	on: To	27. Manner of Death  1. Anatural 5 Pending (Month, Day,	y 28b. Time of		28d. Describe how	ce 6 Other (Specify) injury occurred
Division	I or Attendi after death. Director: A d in by the fu	Certification:	2 Accident investigation	ry - At home, farm, stre (Specify)	M 1 □Yes 2 □No	28f. Location (Stree	et and Number or Rural Route Number,
Ö	Hospital or Attending Physician; 24 hours after death. Funeral Director: After this certificately filled in by the funeral director, itely filled in by the funeral director, itely filled in by the funeral director, itely			(Specify)		City or Town, S	State)
	To the Hospital or I within 24 hours after To the Funeral Dire completely filled in b	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner state	examination and/or inv	occurred at the time, date and place, restigation, in my opinion, death occur	and due to the cau red at the time, date	use(s) and manner as stated. e and place, and due to the cause(s)
	with CO	2	29b. Signature and title of certifier  Abelian Abelian for mo		29c. License number 024781	29d	Date signed (Month, Day, Year)
	151		30, Name and address of herson who completed cause of de	ath (Item) 23a) (Typle, F	Print) ti	to. MD 2	7229
	Sta Registra		31. Date filed (Month, Day, Year)  32. Registra	's Signature	9		

09-04533 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Pamela Bennett 1- For State Certificate of Death Reg. No Registrar 2 Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day June 7, 2009 1802 hrs **Medical Examiner** AME 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore St. Agnes Hospital If Under 1 Year If Under 24Hrs. 8, Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Director Country) MARYLAND 220-06-693 2 V F Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No s 23a or 28a-f show e notified at once. BALTIMORE MARYLAND 10g, Citizen of What Country 10e. Street and Number 526 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status or items must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married Yes Specify: RLACK Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after of If Yes. Give Year Yes 2 No specify: Widowed Divorced marked other than "natural", c event, the Medical Examiner ⋧ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 12TH MONITOR HOUSING DEPT. OF BALTO GRADE 1301LDING 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) HOWARD Be STEPHEN DEBORAH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) other traumatic SR. (HUSBAND) MICHAEL BENNETT 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State BALTIMORE, MARYLAND rtant: 12009 OUDON PARK CEM. Donation 5 Other Specify: 22. Name and Address of Facility SOSEPH H. BRUWN JR. FUNERAL 2140 N. FULTON AVE, BALTIMORE 21. Signature of Funeral Service Licensee 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death Hypertensive Cardiovascular Disease Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and trans Physician/Medical AMENDED 23a, pt.II,27 per me g894 8-20-09 vt physician a X UNPENDED The law requires that the death certificate be Box 68760. 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Month 1 V Live birth 3 Ectopic pregnancy Day Year Fetal death use as t past 12 months? 4 Pregnant at time of death Other (Specify) Jun 7, 2009 5 1 ✓ Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 No 3 Probably 4 🗸 Unknown Obesity, Diabetes Mellitus, Pregnancy page 2 should be Completed 24a. Was an 24b. Were autopsy findings available has been prior to completion of cause of autopsy performed? death? 1 V Yes 2 No ✓ Yes 2 certificate 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Division of Vital director, Be examiner? Other<sub>4</sub> Other Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 After this ဥ 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural n 24 hours after death

e Funeral Director: 
letely filled in by the fin Yes 2 No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide determined (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the I the Lo 0

OK

COME

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Melissa Brassell, MD

29b. Signature and title of certifier

ulu

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

June 8, 2009

31. Date filed (Month

State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year 37 PM 200 June 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore, W If Under 1 Year | If Under 24 Hrs. mD Agnes 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, Days Hours Min 1**⊠**M 2□F Yrs. 7,0009 MARYLANIE Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 Kyes 2 □ No BALTIMORE MARYLAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A AVENUS 526 Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: BLACIS 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NIA N/A C 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) BENNETT SR. PAMELA MICHAEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21229 MICHAEL BENNETT S. (FATHER) 526 YALL BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 Removal from State OUDON PARK CEM. OL/15/2009 ISALTIMORE, MARYLAND 4 Donation 5 Dother (Specify) SERH H. BROWN JR. FUNERAL HOME 21. Signature of Funeral Service Licensee 2140 N. FULTON AVE., BALTIMORE, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Da SEVEVE disease or condition resulting in death) Due to (or as a consequence of): Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Materna Due to (or as a consequence of):

Box 68760, o Records, Division of Vital 24 hours a Hospital

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or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran completely filled in by

**Physician** 

/Medical

Examiner

Funeral Director

Completed by

B

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Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be natified at once.

**Physician** 

Examiner

/Medical

Baltimore, Maryland 21215-0036

Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of of 9 ☐ Unknown	Ideath 3 □ E	Ectopic Other (s		23d. Date of delivery  Month Day Year			
	Part II. Other significant conditions of 25 WEEKS GES	coo use contribute to the cause of death?  2 No 3 Probably 4 Unknown							
Completed by	dysfunction	, metabol	ic Ac	Lich	osis		autopsy prior to completion of cause performed? death?		
Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one)							
၉	1 Yes 2 XNo	Hospital: 1 Inpatient 2 □	ER/Outpatient	3 □ D	Home 5 Residence	ome 5 ☐ Residence 6 ☐ Other (Specify)			
	27. Manner of Death 1 XNatural 5 □ Pending 2 □ Accident investigation		28b. Time of Injury	м	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred		
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specific					Location (Street and Number or Rural Route Number, City or Town, State)		
Medical (		ysician: To the best of my kno niner: On the basis of examina and manner stated.					ise(s) and manner as stated. e and place, and due to the cause(s)		
8									

of death (Item 23a) (Type, Print) tal. 900 Caton Ave. Baltimore, MD Z1229

29d. Date signed (Month, Day, Year)

[WNC 09, 2009

Registrar DHMH 17 Rev 1/2001

within 2.

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30 Name and address of person who completed cause of death Cayolyn MOLONCY, MD ST

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 06 Month Brown 10:55 PM 09 /Medical 4b. City Town, or Location of Death Halfi More 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Hospice Maris Date of Birth (Month, Day, Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 X F Director death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f shov Examiner rust by notified at Baltimore 1 Yes 2 □ No Funeral Director 10e. Street and Number 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 \_\_Yes 2 \_\_No If Yes, Give Ye ar or Dates: "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Black þ 3 ☐ Widowed 4 █ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Union Memoria tssistant 18. Mother's Name (First, Middle, Maiden Surname) To Be Informant's Name/Relationship (Type. Print)
Shin Wright Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margland 21206 . Method of Disposition

Method of Disposition

S □ Removal from State 20b. Place of Disposition cemetery, crematory 15-09 Baltimore, Maryland Vaughn C. Greene Funeral Services 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License C. Areene Bullimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** COLON CANCER /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Understand Cause (Disease or injury that initialed events resulting in death) Last Examine Due to (or as a consequence of): sician and burial-trans Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □Yes 2 K No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA HOSPICE 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 📉 Natural 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attence within 24 hours after death To the Funeral Director; 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29d. Date signed (Month, Day, Year)

State Registrar TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

30. Name and dddress of person who completed cause of death (Item 23a) (Type, Print)

**CRNP** 

JACKIE JONES,

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Lloyd Harvey Baker /Medical 9:35 A Jun 11, 2009 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (If not institution, give street and number) Examiner Montgomery County
9. Birthplace (State or Foreign Holy Cross Nursing & Rehabilitation

5. Social Security Number
6. Sex,
7. Age (In yrs. last birthday) Burtonsville If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 M M 2 □ F 129-16-9052 Usual Residence of Docar Director NY Sep 17, 1927 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notlfied at 1 ☐ Yes 2 No Director Columbia MD Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or 7 Funeral 21045 7110 Minstrel Way 12. Was Decedent Ever in U.S. Arriged Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced White 11 GIW 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) l aw Attorney 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Baker Marion Souville 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jeffrey L. Baker Son 4551 Doncaster Dr. Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 4 Donation 5 ☐ Other (Specify) Atlantic Crematory, LLC

22. Name and Address of Facility Jun 12, 2009 Glen Burnie, MD Signatu of Funeral Service Licensee Slack Funeral Home, P.A.
3871 Old Gelumbia Pike Ellicott City, MD 21943
ock, or heart failure. List nly one cause on each line. Approximate Interval Between Onset and Death diate Cause (Final Sepsis **Physician** di ase or condition re ulting in death) Due to (or as a consequence of):

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interior /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed LASIMMY Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) o. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown heral vancular 24a. Was an autopsy performed? Yes 2 No 1⊟ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 No 4D Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ၉ After this 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1. Natural 5 ☐ Pending investigation 1 TYes 2 TNo M 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0054566 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9801 Creongia Annu # 1-17 Silverspring prozoger Sunisha Bhogavilli 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JUN 1 2 2009

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JUNE 10, 2009 1:15 a.m.

EDWINA BRZOSTEK

			1 - For State Registrar	State of	Marylan		artment of F rtificate of I		and Mer		ene2 () (	9	1.8	899
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nd.	Examir	ier	STELLA MARIS				TIMO!						RE	
	Funeral		5. Social Security Number 6. S	ex 7.	Age (In yrs.		If Under 1 Year Months Days		24 Hrs. 8. Min.	Date of Birth		9. Birthpla	ace (State o	r Foreign
ı	Director	П	212-42-0733	□ M 2 <b>X</b> F	6!	5 Yrs.	Months Days	riours	SE	EPT. 4	1943	MAR	YLANI	)
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10	d. Inside Ci	ty Limits
	Mary a-f sh	tot	MD BALTI	MORE		BAL	TIMORE						1 ☐ Yes	2 <b>X</b> No
	or 28	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of Wh	at Count	ry?	
	s 23a	ral	4720 KENWOOD				212					5.A.		
(0	2 should be filed within 72 hours after death with the Maryland I and Mental Hygiene.  is marked other than "natural", or items 23a or 28a-f show raumatic event, the Mudical Exprehent must be notified at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decede Armed Force 1 ∐Yes 2	es?		Was Decedent of H f Yes, specify Cuba	lispanic Ori an, Mexicar	igin? (Specify n, Puerto Rica	Yes or No- an, etc.)	14. Race - Black,	America White, et		
21215-0036	ral", o	þ	3 ☐ Widowed 4 【X Divorced	If Yes, Give Year or Date			T∐Yes 2 <b>X</b> No	Specify:	•		Specify:	WHI	(TE	
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<b>5</b>	il Hygi other ent, i	BeC	17. Father's Name (First, Middle, Last)					18. Mothe	er's Name <i>(Fi</i>		aiden Surname)			
/lar	uld be Menta arked atic ev	To B	EDWARD KOWAL	EWSKI				AG	SNES	RYBAR	CZYK			
Maryland	2 sho n and is ma rauma		19a. Informant's Name/Relationship (			I	ng Address (Street						,	
e, N	1 and Health em 27 ther tu		AUGUSTA KOWALEW  20a. Method of Disposition	SKI/ SI	STER		) KENWOC	DD AV	/ENUE ,		MORE, M		2120	)6
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mudcal Experiment is as Le notified at once.		1			emetery, cren	NISLAUS					•		۸D.
Ball	permit. Departr Importa any inju		21. Signature of Funeral Service Licen	see		27	L Name and Address 1901 EAS	*ZETT STERN	YER IN	IC. FU NUĖ, BA	NERAL LTIMOR	HOM E, M	E D. 21	1231
П			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	olications that cau	sed the death	n. Do not ent	er the mode of dyin	ng, such as	cardiac or re	spiratory arres	st,		Approximate Interval Bety	ween
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	/Medical Examiner			Due to (or	as a consequ	uence of):								
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8760,	icate be ex <b>e</b> cuted physician and s the burial-transit		resulting in deathy East	Due to (or	as a consequ	uence of):								
		edic		.d										
Вох	leath certifi attending p for use as	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			le				23d. Date	of deliver	ry	
0	The law requires that the death certifi ate has been signed by the attending bage 2 should be detached for use as	Physician/Medical	in the past 12 months? 1 □ Yes 2 <b>X</b> No 9 □ Unknown		h 2□ Feta nt at time of d n		Ectopic pregnancy Other (specify)	у			Monti	n [	Day \	Ye ar
შ.	res that signed b be deta	by PI	Part II. Other significant conditions of	ontributing to deat	h but not resu	alting in the ur	nderlying cause give	en in Part I.		23e. Did toba	acco use contrib	ute to the	a cause of d	leath?
ord	w require been si should b	ted							— L	1 <b>X</b> Yes	2 □ No 3	☐ Proba	ably 4 □ l	Jnknown
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jo:	Attending I r death. ector: After by the funer	atio	1 Natural 5 Pending 2 Accident investigation		Day, Tear)	Injury		Yes 2 □ I	No					
$\leq$		Certification: To	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of building,	Injury - At ho etc. (Specify	me, farm, stre	eet, factory, office		28f.	Location (Stree City or Town,	eet and Number State)	or Rural	Route Num	ber,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical C	29a. Certifier 1 ☐ Certifying Phr (Check only 2 ☐ Medical Exam one)X Nurse Pract	iner: On the basi	s of examina									:)
i	To the within 2 To the Complete	ž	29b. Signature and title of certifier				29c. License	e number	2	29	d. Date signed (	Month, E	Day, Year)	
			1 gg/like	XKNI			1319	1979	12		6/10/0	19		
			30. Name and address of person who o		,	, , , , ,	,				' '	•		
	Sta	te	31. Date filed (Month, Day, Year)	NP 2300 32. Regi	<b>DULAN</b> istrar's Signa	EY VAL	LEY RD.	TIMO	NIUM,	MD 2109	93			
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Medical Examir		James		Berkov	rec					June 7, 2	2009	c. County of	Dooth	1020 111	S
K.		4a. Facility Name (if not institution Shady Grove Advention		imber)			City, Town, or Rockville					Montgom	ery	<del></del>	
Funeral	T	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	-	If Under 1 Yea Months Day		Min.			I/DD/YYYY)	Count	try)	or Foreign
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Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Director	7500 Woodmont	- Avenue	<i>‡</i> 706		1	208	314			Un	ited S	tate	S	
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212 212 Ment be mark	P	19a. Informant's Name/Relation		_	19b. Ma	iling A	Address (Stre	et and Num	nber or Ru	ural Route N	lumber,	City or Towr	ı, State, Z	Zip Code)	
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altir mit. 1 partm porta ury or		Donation 5 Other Specify:  Signature of Funeral Service Licensee  Crematorium, Inc.  2009 Bethesda, Maryland  22_Name and Address of Facility Robert A Pumphrey Funeral Home / Bethesda—Chevy Chase, Inc.													
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(ecc	Completed										erformed es 2		✓ Yes	s 2	No
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Sion Attendath death sector:	cati	Natural 5 Pending Jun 7, 2009 1324 1115 1 Yes 2 No											lumber, City		
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be deach	Certification:	or Town, State)  or Town, State)  determined (Specify) Rike Trail  2300 Blk Baltimore Avenue, Rockville, MD													
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitions.		29a. Certifier	Physician: To the b	est of my know	ledge, death	occurr	ed at the time.	date and p	lace, and	due to the o	cause(s)	and manne	r as state	ed.	
thin 24 the F	Medical	(Check only one) 2 Medical Ex	xaminer: On the basi and manne	s of examinatio	n and/or inve	stigati	on, in my opini	on, death o	occurred a	it the time, d	late and	place, and	due to the	e cause(s)	
To Too	Me	29b. Signature and title of certi		Glatou.		29c. License number					29d. Date signed (Month, Day, Year)				ear)
		/ Latur	(bevs)				0.0	C.M.E.			J	une 8, 20	109		
		30. Name and address of person	on who completed ca	ause of death (I	tem 23a)		<u> </u>		40.01	104					
		Laron Locke MD.	Assistant Medi	cal Examine	er 111 F	enn	Street, Bal	timore, N	VID 212	:U1					

Registrar

State 31. Date filed (Month, Day, Year)

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** EUINS MARION 200 9 EDWARD JUNE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPITALC HESTER STERTOWN INE 8. Date of Birth (Month, Day, Year) Aug. 30,1934 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Maryland Months Days Hours 1⊠M 2□ F 212-30-7195 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show ed other than "natural", or items 23a or 28a-f show event, the twelfen Evanding must be notified at Maryland Kent Chestertown 1 □ Yes XXNo Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21620 7543 Sunburst Ave. United States death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 ☒ No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 21X No Specify. \$ Specify: 3 Wildowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) permit. Pages 1 and 2 should be filed within 7;
Department of health and Mental Hygiene.
Important: If item 27 is marked other than "ns any injury or other traumatic event, the Medicons. Elementary/Secondary (0-12) 10 Years College (1-4or 5+) Truck Driver Trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Timothy F. T. Blevins Bessie M. Ashley ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Madeline Blevins (Wife) 7543 Sunburst Ave. Chestertown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 6/15/2009 Baltimore, Maryland 4 ☐ Donation \_ 5 ☐ Other (Specify) uneral Service License 22. Name and Address of Facility Duda-Ruck funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart telemore list only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Concer MONTHS ning disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events Examiner Due to (or as a consequence of) ending physician and use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 □Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate acrite Division of Vital 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No the Hospital or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Lopatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred After Certification: 5 Pending investigation 1. Zi Natural death. 1 □Yes 2 🗌 No 2 Accident ofter death 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated.

State

Registrar

29b. Signature and title of certifier

PANL W. Morte

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100 Brown

32. Registrar's Signature

St. Chestertonn MS 2/620

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 4:37PM **BECKER** ELSIE R Tune 09 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hospital of Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 ☐ M 2 🕇 F Months Days Hours 10/24/1926 219-20-9099 82 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No N/A BALTIMORE 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 5703 RUSK AVENUE 21215 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🐧 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married WHITE 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BENJAMIN RUTTENBERG CHEPOVSKY CLARA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ADRIANE BECKER / DAUGHTER 228 TIDYMAN ROAD, REISTERSTOWN, MD 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State HEBREW YOUNG MENS 06/11/2009 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final reumonia 1 day disease or condition resulting in death)

Physician /Medical Examiner Physician/Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

MD

**Funeral** 

Director

28a-f show

items 23a or

Funeral

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Completed

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death with the Maryland

1 and 2 should be filed within 72 hours after Health and Mental Hygiene.

Pages 1

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Department of Health Important: If item 27 any injury or other the once.

Maryland 21215-0036

Baltimore,

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anding physician and use as the burial-tran

Division of Vital Records, P.O. Box 68760,

	resulting in death)	Due to (or as a consec	uence of):				/
	Sequentially list conditions,	b. Septic s	shock				4 days
njnei	if any, leading to immediate	Due to or as a consec	juence of):				,
cal Exan	Cause (Disease or injury that initiated events resulting in death) Last	C	uence of):				
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregn. 1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 Ecto	pic pregnancy r (specify)		23d. Date o Month	delivery Day Year
y P	Part II. Other significant conditions of	contributing to death but not res	ulting in the underly	ng cause given in Part I.	. 23e. Di	d tobacco use contribu	te to the cause of death?
ed k	CVA				10	∐Yes 2∏No 3[	Probably 4 Unknown
Complet					pe	topsy prio rformed? dea	e autopsy findings available to completion of cause of th? Yes 2 2No
Be	25. Was case referred to medical examiner?			26. Place	of Death (Check only	y one)	
	1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3	□ DOA Other: 4 □ Nu	ursing Home 5 ☐ Re	esidence 6 Other	Specify)
ation:	27. Mannar of Death 1		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐		e how injury occurred	
Medical Certification: To	3 Suicide 6 Could not by determined		ome, farm, street, fa	ctory, office	28f. Location City or 7	(Street and Number o own, State)	r Rural Route Number,
edical	29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exam	nysician: To the best of my kno miner: On the basis of examina and manner stated.	owledge, death occu ation and/or investig	rred at the time, date ar ation, in my opinion, dea	nd place, and due to that hoccurred at the time	he cause(s) and mann e, date and place, and	er as stated. due to the cause(s)
Σ	29b. Signature and title of certifier	-		29c. License number		29d. Date signed (A	fonth, Day, Year)
	1 hours	mu		RES- OF	0	June 0	5, 2009

Hospital

State Registrar

31. Date filed (Month, Day, Year)

within 24 hours a

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Adhanom, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 18903 2009 1- For State Certificate of Death Rea. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ June 6, 2009 Medical Examiner 2010 hrs Kyle Bianchi 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford Aberdeen Proving Ground Edgewood 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign **Funeral** Country Months Min Davs Hours 220-29-5946 Director 1 X M 2 F 18 Yrs 10/25/1990 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 X No 23a or 28a-f show notified at once, MD Baltimore Baltimore death with the Maryland Director 10e. Street and Numbe 10g. Citizen of What Country 10f. Zip Code 29 W. Elm Avenue 21206 U.S.A. Funeral 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married 2 X No Yes hours after White Divorce Widowed Yes, Give Year Yes 2 X No specify: Specify: ₫ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Baltimore City Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene
Important: If item 27 is marked other than ",
injury or other traumatic event, the Medical I MD 21215-0036 Public Schools 12 Student 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Richard Bianchi Robbin Μ. **Powers** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Bianchi, Father 29 W. Elm Avenue, Baltimore, MD 21206 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date Baltimore, crematory or other place) 1 X Burial 2 Cremation Removal from State Moreland Memorial Park 06/11/2009 Baltimore, Maryland Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licenses eonard J. 5305 Harford Road. Baltimore, 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death Immediate Cause (Final disease xaminer a Drowning or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or link y that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed Physician/Medical AMENDED 23a,27,28a-f,permE, G893 7/23/09 TT X UNPENDED attending physician or use as the burial -Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year Fetal death Dav 2 past 12 months? Pregnant at time of death Other (Specify) signed by the atte 1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. ģ 1 Yes 2 V No 3 Probably 4 Unknown Completed icate has been s page 2 should b 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? certificate ✓ Yes 2 1 🗸 Yes 2 No No the Hospital or Attending Physician: nin 24 hours after death. the Funeral Director: After this certiff 25. Was case referred to medical 26.Place of Death (Check only one) æ examiner? Other; Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene 1 ✓ Yes ဥ No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural subject drowned in river Yes 2 X No 1 Director: ed in by the f Pending 6/6/2009 FD 1945 hrs 2 X Accident Investigation filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) Aberdeen Proving Ground, Edgewood, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide Gun Powder River determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal To the 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 7, 2009 30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar's Signature

DHMH 17 Rev 1/2001 OCMF 2006

Registra

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Time of Death June **Physician** Doris Collins 10, 2009 7:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4227 Euclid Avenue Baltimore N/A 8. Date of Birth (Month, Day, Year) Aug 23, 1912 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🗓 F 96 Director 213-10-9287 Maryland Usual Residence of Decedent 10a State 10b County 10c City Town or Location 10d Inside City Limits show event, the Medical Examiner must be notified Director 1 Yes 2 □ No 28a-f N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō filed within 72 hours after death with 21229 4227 Euclid Avenue 23a Funeral "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify. Specify: White þ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ns any injury or other traumatic event, in Imaging Once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Charles Gilbert Bessie Baldwin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4227 Euclid Avenue Baltimore, <u>Patricia Sha</u>nahan, Daughter Maryland 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc.: 06/12/09 Baltimore, Maryland 21. Signature of Funeral Service Licence Thomas Gregor <sup>22</sup> Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** oronary MKNOW disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): ll any leading to inmedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the as the attending IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 ☐ Other (specify) ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed page 2 should been Were autopsy findings available prior to completion of cause of death? 24a. Was an has certificate performe 1 ☐ Yes 2 1 ☐ Yes 2 No Hospital or Attending Physiclan: completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 1 ☐ Yes Certification: To this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Mannal of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a Certifier cal 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the 29b. Signature and title of certifier 0 29c. License number 29d. Date signed (Month. Day, Year) Name and address of person who ted cause of death (Item 23a) (Type, Print) Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

405 Frederick Road

Catonsville, MD

cause of death (Item 23a) (Type, Print)

32, Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			. For	State of	of Ma	ryland /	Depa	artment	of Hea	Ith and M	lental Hy	giene	•		
			1 - State Registrar			-	Cer	rtificate	of Dea	ath		Reg. No.	2009		8906
	Physicia		Decedent's Name (First, Middle,     Malcolm Jeffer	,	er .	Jr.					2. Date of De Month June	ath 10,	2009 Year		ime of Death :50 PM
	/Medic Examin		4a. Facility Name (If not institution, 2700 Duvall Ro	give street and nu		-				ation of Death			County of Death	1	
and the second				6. Sex	7 Age	(In yrs. last	hirthday)	If Under 1	lbine Year I If L	Inder 24 Hrs.	8. Date of Bi	rth	Howard 9. Birtl		State or Foreign
	Funeral Director		427-90-5565	1 <b>X</b> M 2□ F	7,7,90		Yrs.			ours Min.	8. Date of Bi (Month, D March	17,19	948 Ten	intry) nes	-
	w w		Usual Residence of Decedent  10a. State 10b. County			10c. City, To	wn or Lo	cation						10d. In:	side City Limits
	Maryla f sho	to	Maryland Howard				lbine							1 [	□Yes 2√□No
	r 28a	Director	10e. Street and Number					10f. Zip (	Code			10g. Cit	izen of What Co	untry?	
	th with	al D	2700 Duvall Road	<u> </u>					21797			US	SA		
	rdea	Funeral	11. Marital Status	12. Was Dec Armed F	orces?		13. \	Was Decede	ent of Hispar fy Cuban, M	nic Origin? (Sp exican, Puerto	ecify Yes or No Rican, etc.)	)-	14. Race - Ame Black, White		dian,
36	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Exactions must be reaffied at	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 🂢 Divorced	ed 1 ∏Yes If Yes, G Year or [	ive	0		1 🗆 Yes 2	XNo Sp	pecify:			Specify: W	nite	
21215-0036	2 hour	ted	15. Decedent's	s Education		10	6a. Deced	dent's Usual	Occupation			16b. Ki	ind of Business/l	ndustry	
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Maryland	d d	Be	17. Father's Name (First, Middle, L. Malcolm Jeffers	*					18.		e Haney	, waiueri	Surname)		
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altimore,	Pages ment of ant: If Its lury or o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	ecify)		Metr	o Cr	emator	y Inc	. 06/1			timore,		
Ball	permit. Pages Department of Important: If II any injury or o		21. Signature of Funeral Service L	icensee Thorr	nas (	Gregor	2.25 2.5	Name and remati 99 Fre	Address of Lon So ederic	ciety ( k Road	Of Mary Baltim	land	, Inc. Maryla	nd 2	1228
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	/Medical Examiner		resulting in death)	Due to	(or as a	consequenc	ce of):	7.1							
	1	e	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a	consequence	ce of):								
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ROX	leath atten	cian	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2	2 ☐ Fetal de time of deatl	ath 3	Ectopic pro				ĺ	23d. Date of del Month	Day	Year
л. О	The law requires that the death certificate has been signed by the attending age 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 □ Unk											
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Division of	r Atterde ter de l'recto	ertification:	3 Suicide 6 Could no 4 Homicide determine	ned Zoe. Plac	e of Injur ding, etc.	ry - At home . (Specify)	, farm, str	eet, factory,	office		28f. Location City or To	(Street ar	nd Number or Ri e)	ural Rou	ıte Number,
2	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, it	O	29a. Certifier CertifyIng	g Physician: To th	e heet o	f my knowle	dae deat	h occurred a	at the time.	date and place	and due to th	e causels	and manner a	s stated	1
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	To th withir To th	Me	29b. Signature and title of certifier					29c.	License nui			29d. Da	ate signed (Mont	h, Day,	Year)
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	12		30. Name and address of person v						0.201	. C-1	hi - M	1		,	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. ZU Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Year 05 PM 2009 Tune Belle Crowl /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Baltimore rank 5. Social Security Number If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. ast birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🛛 F Months Days Hours Director 3/1/1938 West Virginia <u>234–62–8435</u> Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Eventual Lives Institute and once. 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2X No Director Maryland Baltimore Rosedale 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21237 <u>7419 Brightside Avenue</u> U. S. Α. 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2√∑ No þ Specify: 3 X Widowed 4 □ Divorced White Baltimoré, Maryland 21215-0 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Smith Dewey Thelma Barnhart 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Tony Russell Crowl (Son)</u> 7419 Brightside Avenue Rosedale, Maryland 21237 Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 6/12 4 Donation 5 Other (Specify) Holly Hill Memorial Gard. 2009 Middle River, Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue 21. Signature of Funeral Service Licenses PA Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or a a consequence of); Examiner neuMoni Sa puentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, requires that the death certificate be Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 5 Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has performe 1 ☐ Yes 2 XNo 1 ☐ Yes 2 ☐ No or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 💢 Inpatient After this 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Fo the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and tit 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) inger 9000 Franklin Square Drive Baltimore Md

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 9:55 DM Coates Sr. Douglas M. TUKE 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE CITY SAINT AGNES NOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 05 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** <sup>Year)</sup> 28 Days 1 → M 2 □ F MD 215-24-9762 Director 81 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2X No Director Catonsville Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21228 U.S.A. 16 Winters Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married 1 □Yes 2 🗓 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Coates Movers 8th grade Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ Ridgley Coates
19a. Informant's Name/Relationship (Type. Print) Edna Savoy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 Winters Lane, Catonsville, Md 21228 Patricia Coates-Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date W Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 6/15/2009 Woodlawn, Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licensee 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death YEARS Immediate Cause (Final CORONARY ARTERY DISEASE **Physician** 

**Examiner** Douglas

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After t filled in

72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

28a-f show

7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, "na Medical Experience must be notified at

12 should be filed within 7 in and Mental Hygiene.
7 Is marked other than "n.

permit. Pages 1 and 2 sl Department of Health an Important: If item 27 is r any Injury or other traur

/Medical

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resulting in death)	Due to (or as a consequence of):	2/2		
O and the first and the first	DIABETES ME	LLITUS		YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):  CONGESTIVE HEA	ART FAILUR	E	YEARS
resulting in death) Last	C Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		opic pregnancy er (specify)	1	Date of delivery Month Day Year
Part II. Other significant conditions o	contributing to death but not resulting in the underl	ying cause given in Part I.	23e. Did tobacco use c	contribute to the cause of death?  o 3 Probably 4 Unknown
			24a. Was an autopsy performed? 1 □ Yes 2 🗷 No	tb. Were autopsy findings available prior to completion of cause of death?  1 □Yes 2 □No
25. Was case referred to medical		26. Place of Dea	ath (Check only one)	
examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 ☐ Inpatient 2 🔀 ER/Outpatient 3	□ DOA Other: 4 □ Nursing H	lome 5 Residence 6	Other (Specify)
27. Manner of Death  1   Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occ	
3 Suicide 6 Could not be determined		actory, office	28f. Location (Street and Nu. City or Town, State)	umber or Rural Route Number,
	niner: On the best of my knowledge, death occ miner: On the basis of examination and/or investi and manner stated.			
29b. Signature and title of certifier		29c. License number	29d. Date sig	gned (Month, Day, Year)

D46505

HUSPITAL

JUNE 7. 2009

State Registrar

completely

29b. Signature and title of certifier

Nanna 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Budstraf's Signature

WAN MOH

OKKINES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Martha Rebecca Chichester 2009 06 08 1415 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 804 East Randolph Rd. Silver Spring Montgomery Birthplace (State or Foreign Country) 5. Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 3/22/1915 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year Days Months Hours 1 ☐ M 2 🙀 F 218-30-3859 Yrs. 94 DC Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits 1XYes 2 No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 804 East Randolph Rd. 20904 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Bureau of Engraving Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Augustus B. Hill Delia Moton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis E. Davis/ Daughter 804 East Randolph Rd. Silver Spring MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Maryland Nat. Park 6/15/2009 Laurel, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall's FUneral Home 23a. Part littler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4217 9th St. NW Washington DC 20011 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ur as a consequênce of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Dav 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 1 Yes 2X No 26. Place of Death (Check only one) Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 2 Accident

/Medical **Examiner** physicien and s the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, signed t icate has been siç , page 2 should b certificate or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director,

**Physician** 

**Examiner** 

**Funeral** 

Director

"natural", or items 23a or 28a-f show dical Examens: must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with t. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Exam at must be no once.

**Physician** 

altimore, Maryland 21215-0036

Funeral Director

þ

Completed

Be

Examiner

Physician/Medical

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Completed

Be

Certification: To

Maryland

the

/Medical

Diabetes Mellitus Hypothyroidism

**Blindness** 25. Was case referred to medical examiner? 1 XYes 2 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

3 Suicide

29a. Certifier

4 \( \text{Homicide} \)

6 Could not be determined

M. D 30. Name and address of person who completed cause of peath (Item 23a) (Type, Print)

29c. License number D15146

29d. Date signed (Month, Day, Year)

06/11/09

To the Hospitat

State Registrar

Antonio G. Uy MD. 31. Date filed (Month, Day, Year)
JUN 1 2 2009

354 University Blvd. West Silver Spring, MD. 21902 32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month 5:25 P Shashi Chopra Jun 10, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7504 Sea Change Columbia Howard Birthplace (State or Foreign Country) 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) **Funeral** Min. 1 □ M 2 1 F Months Days Hours Director India 577-11-4817 Mar 15, 1932 Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Evanther must be notified at 1 ☐Yes 2 🗷 No Director Columbia MD Howard death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7504 Sea Change 21045 12. Was Decedent Ever in U.S. Armed Forces?

1 
Yes 2 No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Yes. Give Completed by 3 ☐Widowed 4 ☐ Divorced De 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Cosmetology Hair Dresser permit. Pages 1 and 2 should be filed Department of Health and Mental Hy Important; If item 27 is marked other any lijury or other traumatic event, 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Ram Swaroop Thapar Gayatri Thapar 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr. Gita Bakshi Daughter 4926 Glenbrook Rd. Washington, DC 20016 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 | Removal from State Jun 12, 2009 Sykesville, Maryland All County Cremation Services, 22. Name and Address of Facility 21. Signature of Funeral Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) **Physician** .മെമനധറ /Medical Examiner Sequentially list conditions, it any, leading to initial accause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner burial-tran resulting in death) Last Due to (or as a consequence of): physician at the burial P.O. Box 68760 Physician/Medical attending pl for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month 5 Other (specify) □Yes 2 No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, ₽ 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 autopsy performed certificate 1 □Yes 2 No 1 □Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tyes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D20789 June 11, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Flowers, William MD 11055 Little Patuxent Parkway, Suite 104

Registrar

State

31. Date filed (Month, Day, Year) 32. Registrar's Signature

			For State Registrar	State of I	Maryland		rtment <i>tificate</i>			and Mo		giene Reg. No. 1	200	9	18911
			1. Decedent's Name (First, Middle, Las	")		-					2. Date of De Month	ath Day	Yea	ar	3. Time of Death
	Physici /Medic		FRANCES CLINT	ON						:	TUNE				6:20 PM
and a	Examin		4a. Facility Name (If not institution, give STELLA MARIS	street and number	er)		4b. City, To	NIUl	M			В.	County of D	ORE	
	Funeral Director		232-05-7912	x 2 <b>X</b> F 7.	Age (In yrs. la		If Under 1 Months	Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da ct, 24	th 191	8 We	Countr S <b>t</b>	v) Virginia
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation							100	d. Inside City Limits
	Mary Ff sh	to	MD Baltimor	:e	Time	nium									1 □Yes 2 No
	or 28s	Director	10e. Street and Number				10f. Zip 0	Code				10g. Citiz	en of What	Countr	y?
	23a c	ra [	2428 Chetwood Circ					210					USA		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar I. ust be neithed at once.	by Funeral	11. Marital Status  1 ☑ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date	s? X No		Was Decede fYes, specif 1 □Yes 2		ispanic Ori n, Mexicar Specify:		cify Yes or No Rican, etc.)		4. Race - A Black, W Specify: V	hite, et	c.
Maryland 21215-0036	hour	pe	15. Decedent's Edi	ucation	s.	16a. Dece	dent's Usual	Occupa	ation			16b. Kin	d of Busine	ss/Indu	ustry
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pu	be file tal Hy d oth event	Be	17. Father's Name (First, Middle, Last)								(First, Middle				
yla	ould I	٩	Devon Eskey Clint			T 401 14 11					ephine I Route Numb				Codal
Mai	d 2 sh th and 7 is n traun		19a. Informant's Name/Relationship (7 Stella Maris Hosp								d Tows	-			
ē,	1 and Heal tem 2		20a. Method of Disposition	100	20b. Pl	lace of Dispo				•	ate 10WB		cation - City		
ē	Pages ment of l ant: If its ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☑ Donation 5 ☐ Other (Specify		ite Ce	emetery, crer	natory or otr	ier piac	e)						
Baltimore,	permit. Departm Importa any Inju		21. Signatur Ronald S	åde, Ivr	V	Ba	altimo	re.	Mary	land	21201		altim	ore	Street
			23a, Part1. Enter the disease or comp shock, or heart failure. List only	ncations that cau	sed the death	. Do not ent	er the mode	of dyin	g, such as	cardiac o	r respiratory a	arrest,			Approximate Interval Between
U,	Physician		Immediate C se (Final disease or condition	ENI	577	166	CAR	00	1C	Dis	SEASE				Onset and Death
	/Medical		resulting in death)	Due to (or	as a consequ	uence of):									
Ì	Examiner	<u></u>	Sequentially list conditions	b. Due to for	as a consequ	longo of									
	ted nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequ	rence on.									
<u>,</u>	execu in and ial-tra	Examine	that initiated events resulting in death) Last	Due to (or	as a consequ	ience of):			-				***************************************		
8760,	cate be executed oblysician and the burial-transit	dical		.d										_	
9	ertifica ing ph	Med	IF FEMALE:												
O. Box	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as:	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown		th 2 Fetal nt at time of d	death 3	☐ Ectopic pr ☐ Other <i>(sp</i> e		у			2	23d. Date of Month		ry Day Year
σ.	e law requires that the de has been signed by the ie 2 should be detached		Part II. Other significant conditions of	ontributing to deat	h but not resu	ulting in the u	nderlying ca	use giv	en in Part	l.	23e. Did	tobacco u	se contribu	te to th	e cause of death?
rds	quires an sign	ed by									10	Yes 2	No 3[	Prob	ably 4 ☐ Unknown
ပ္သ	aw rec	Completed									24a. Was		24b. Wer	e autor	osy findings available inpletion of cause of
Ä	The Is	E								-	perf 1 □ Yes	opsy ormed? 2 <b>X</b> No	dea	th?	2 □ No
ta		Be C	25. Was case referred to medical examiner?						26. Plac	e of Death	(Check only				
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n	ling P	i.i	27. Manner of Death 1 Natural 5 □ Pending	, ,	Injury Day, Year)	28b. Time o Injury	nt 28	Bc. Injur Worl		_	28d. Describe	how injur	y occurred		
Division of Vital Records,	or Attending Physician: sifer death. Director: After this certific in by the funeral director, I	Certification: To	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e, Place of	Injury - At ho , etc. <i>(Specif</i> )	ome, farm, st		-	Yes 2□		28f. Location City or To	(Street an own, State	d Number (	or Rura	l Route Number,
	Hospital 4 hours a Funeral I	edical Ce	29a. Certifier 12 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the b niner: On the bas and manne	is of examina	wledge, dea tion and/or it	th occurred anvestigation,	at the ti in my c	me, date a	and place, eath occur	and due to th	e cause(s e, date and	) and mann d place, and	er as s	tated. the cause(s)
	To the within 2 To the Complete	Mec	29b. Signature and title of certifier	PRACTIT			290	Licens	se number			29d. Da	te signed (/	Month,	Day, Year)
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			30. Name and address of person who	completed cause	of death (Item	n 23a) (Type,	Print)	10					1 - 1		
					O DULA		ALLEY	ROA	D TI	MONI	UM, MD	2109	3		
	Sta	ate	31. Date filed (Month, Day, Year)	32. Reg	gistrar's Signa	ture	1								

5, 2009

FRANCES CLINTON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Langston 6 Maceo /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number Examiner Baltmore Iniversity of Maryland Medical Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** Days 1**X** M 2□ F July 18, 1939 Pennsylvania Director 072-32-6340 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Medical Examinar must be notified at 1 ☐ Yes 2 X No Director Belcamp Maryland Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 1300 Foxglove Square 21017 Funeral 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 27 No Specify. ð 3 ☐ Widowed 4 ☐ Divorced Black Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Law Enforcement Correctional Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vivienne Louise Hamptonie Gwyn S. Clark ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1300 Foxglove Square, Belcamp, Maryland, 21017 Vivian G. Clark / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【T Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 6/15/2009 Towson, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral Service License 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one case, on each line. Immediate Cause (Final Mach **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and Due to (or as a consequence of) buriaf-t Box 68760. pe Physician/Medical the attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the a P.0. 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed 1 Yes 2 □No 26. Place of Death (Ch. ck only one) 25. Was case referred to medical examiner? funeral director, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To 28b. Time of Injury ie Hospital or Attending Pl n 24 hours after death. Ie Funeral Director: After th 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the I within 2. 29c. License number NP 1# 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)
JUN 1 2 2009

NASRACE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

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Chinling Bsavino
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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UNK		1- For State Certificate C	of Death Reg. No.
Physicia Exami	an/	Registrar 1. Decedent's Name (First, Middle,Last) Chin Ling Disavino	Month Day Year 1336 hrs May 29, 2009
		4a. Facility Name (if not institution, give street and number) 124 N. Huron Street	4b. City, Town, or Location of Death Forest Heights  4c. County of Death Prince George's
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country), rs. Days Hours Min. 05/15/1963 China
эм япу		Usual Residence of Decedent  10a. State  MD  10b. County Prince Georges  10c. City, Town or Loc Forest	Heights 1 Yes 2 No
vith the Maryland s 23a or 28a-f show a	Director	10e. Street and Number 124 North Huron St.	10f. Zip Code 20745 USA
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiers And Mental Examiner must be notified at once	<del>=</del>	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	Was Decedent of Hispanic Origin? (Specify Yes or No- fryes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  Asian  Specify:
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filted within 72 hours after death wi Department of Health and Mental Hygiene. Important I filem 27 is marked other than "natural", or items injury or other tranumatic event, the Medical Examiner must be	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	dent's Usual Occupation (Give kind of work done g most of working life. DO NOT use retired)  16b. Kind of Business/Industry  Unk  Unk
21215-0036 puld be filed within 7 Mental Hygiene. marked other than	Be Com	dith Chana Un	18. Mother's Name (First, Middle, Maiden Surname) Feng Chao-Lin
MD 212 d 2 should be lth and Ment n 27 is mark	10 E	19a. Informant's Name/Relationship (Type, Print)  Teddy Wu/Brother  19b. Ma 114	illing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  O9 Stonecrop Place Richmond, VA, 23236  sposition (Name of cemetery, Tupped 5 20c. Location - City or Town, State
Baltimore, I ocenit. Pages 1 and Department of Heal Important: If item injury or other tra		1 Burial 2 Cremation 3 Removal from State Chesap 4 Donation 5 Other Specify:	June 5, 200. Location - City or lown, State Deake Crem. June 5, 2009  Beltsville, MD  22. Name and Address of Facilit CAFA/Stephen D. Lohrmann P. A
	_	21 Signature of Funeral Service Licensee 12 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	8717 Green Pastures Dr. Balto, MD 2128
Physician Medica camine	1	failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Asphyxia  Due to (or as a consequence of):	Death
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	
cuted	Lansit		d per ME g892 6/29/09 TT
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director: After this certificate has been signed by the attending physician and	or use as the ourtar - us	UNPENDED  IF FEMALE:  23c. If yes, outcome of pregnancy  1 Live birth  2 past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions  Contributing to death but not resulting in	Fetal death 3 Ectopic pregnancy Month Day Year  Other (Specify)
D.O. BC that the de	detacned	Part II. Other significant conditions contributing to death but not resulting in	1 Yes 2 No 3 Flobably 4 Official
cords, P.O. law requires that the	e 2 should be	COMPANY AND THE PROPERTY OF TH	24a. Was an autopsy findings availab prior to completion of cause of death?  1  Yes 2 No 1 Yes 2 No
ial Recian: The	or, page		26.Place of Death (Check only one)
Vita hysician this cer	-∃ B	examiner?  Hospital: 1 Inpatient 2 ER/Outp	atient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene
on of vending Phath.			D: 1 Yes 2 No Subject placed plastic bag over head
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:	illed in by	3 Suicide 6 Could not be determined (Specify) Single Family	or Town, State) 124 N. Huron Street, Forest Heights , Md
Di To the Hospital within 24 hours To the Funeral		29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or invand manner stated.  29b. Signature and title of certifier	estigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29d. Date signed (Month, Day, Year)
	5	29b. Signature and title of certifier  And Hall a	O.C.M.E.  290. License number  May 30, 2009
		30. Name and address of person who completed cause of death (Item 23a)  Carol Allan, MD Assistant Medical Examiner 111 P	enn Street, Baltimore, MD 21201
10 V	64	31 Date filed (Month, Day Year) 32. Registrar's Signature	A
Re	Sta	111N 1 2 2009 Person S. San	W. /

Registrar
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DUFF

PATRICK

JACKIE JONES,

31. Date filed (Month, Day, Year)

30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print)

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

32. Registrar's Signature

Registrar

State

Fang Yin

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Good Samaritan Hospital
y, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert

Dixon,

5601 Loch Raven Blud, Baltimore,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Name (First, Middle, Last) nonth **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death Eacility Name (If not institution, Examiner 9. Birthplace (State or Foreign Date of Birth (Month Day **Funeral** 20-18-6686 Director Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Modical Examiner must be rediffed a once. 1 ☐ Kes 2 ☐ No **Funeral Director** 10g. Citizen of What Country? Street and Numbe Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant' Name/Relationship (T) Baltimore, Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5 ☐ Other (Specify) ure of Funeral Service 155 of partiplications that caused the death. Do not enter the mode of sing, such as cardiac or respiratory arrest, ist only one cause on each line. 23a. Part 1. Enter the disease, or soll shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, IF FEMALE: To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use. 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☑ No 1 ☐ Yes 💆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: A Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient Certification: To 1 ☐ Yes 2 ER/Outpatient 3 DOA 27. Man of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Sigrature and title of certifier

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State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ham Woods Mood

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 4:55 P Jup 10, 2009 Tillie Donaldson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Angels Touch Assisted Living
5. Social Security Number 6. Sex 7 479 //2 West Friendship Howard If Under 1 Year Birthplace (State or Foreign Country) rs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 X € Yrs. Director 146-09-0212 Jul 4, 1911 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director **Fulton** MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or Pages 1 and 2 should be filed within 72 hours after death with 20759 7028 Logan Berry Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. <u>ک</u> 3 Widowed 4 □ Divorced Year or Dates: Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) NK Own Home <u>Homemaker</u> marked other 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any linjury or other traumatic event, once. 17. Father's Name (First, Middle, Last) ၉ **Charles Hirtes** Catherine Ley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7028 Logan Berry Lane Fulton, MD 20759 Raymond Donaldson Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4☐Donation 5☐Other (Specify) Jun 13, 2009 Paramus, NJ George Washington Memorial 22. Name and Address of Facility 21. Signature of Funeral Service License Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death 23a. Part in Enter the disease, or complications that caused the death. shock, or heart failure. List only one gause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, neral Director: After this certificate has been signed by the attending physician filled in by the funeral director, page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>^</u> 2 **N**o 3 ☐ Probably 4 ☐ Unknown 1 Tyes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed yes 2 ☑No 2 🗆 No 1 ☐Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 2 1 No 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify, Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier отпретегу and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day,

JUN 1 2 2009

. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** .000M LEONA SILVER DAVIS 7009 imo /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1□M 2X F Months Hours 04/21/1924 212-22-5510 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant; If Item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, The Medical Experiment must be notified at ury or other traumatic event, The Medical Experiment must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State or than "natural", or items 23a or 28a-f show 1 X Yes 2 □ No Completed by Funeral Director MD N/A BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21210 USA 111 HAMLET HILL ROAD - UNIT 507 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: WHITE If Yes, Give Year or Dates: 3 X Widowed 4 Divorced 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) LIQUOR STORE OWNER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BERTHA LEVY SILVER 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8417 STEVENSON ROAD, BALTIMORE, MD 21208 BRUCE HOFFBERGER / SON 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of It
Important; If Ite
any injury or ot
once. 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State RANDALLSTOWN, MD BETH EL MEMORIAL PARK: 06/11/2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** Atheroscierotic resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in a ling to an access the conditions of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of: Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical been signed by the attending p should be detached for use as IF FEMALE: ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 □Yes 2 □ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>გ</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performed? 1 □ Yes 2 No certificate 1 ☐ Yes 2 ☑No within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, I Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other Specify NS HOSPICE Hospital: 1 Tes 2√ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 😭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

DHMH 17 Rev 1/2001

2835 Smith Avenue Sute 203 Bartman Mozizon

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LEDDIE

JUN 1 2 2009

31. Date filed (Month, Day, Year)

1 - For State Registrar

Director

Funeral

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Completed

Be ၉

Examiner

Physician/Medical

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Completed

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Certification: To

Medical

**Physician** 

/Medical

Examiner

**Funeral** 

Director

For State Registrar		Maryland			te of L	Death		Reg	. No. 🤈	100	IRQI
1. Decedent's Name (First, Middl	e, Last)							2. Date of Death	-	Va ==	3. Time of Death
HUGH A. ELLI	OTT, JR.							Month JUNE	Day	Year 2(21(219)	02:35A M
a. Facility Name (If not institution	· · · · · · · · · · · · · · · · · · ·	nber)		4b. City	, Town, or	Location	of Death			ty of Death	
Saint Josep	h Medica	1 Cent	er			T	OWSC	n		Balt	imore
. Social Security Number		7. Age (In yrs. la	ast birthday)	If Unde	er 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day,	(ear)	9. Birth	place (State or Foreign
217-18-6464	1 <b>X</b> M 2 □ F	86	Yrs.	Months	Days	Hours	WIII.	5/4/192			YLAND
sual Residence of Decedent											Od Incide City Limite
Da. State 10b. County			, Town or Lo								10d. Inside City Limits 1 □ Yes 2 <b>X</b> No
MD BALT	TIMORE		IOWSON								
e. Street and Number				10f. Z	ip Code			10	g. Citizen o	f What Cou	ntry?
1647 MUSSULA F	ROAD				21	1286			J	JSA	
. Marital Status		dent Ever in U.S	5. 13.	Was Dece	edent of H	lispanic Or	igin? (Sp	ecify Yes or No- Rican, etc.)		ace - Ameri lack, White,	
1 ☐ Never Married 2 Mar		2 🔲 No		1 □ Yes	_	Specify		7.1104.11, 0.101,		ifer	
3 Widowed 4 Divorced	Year or Da	ates: WWII		1 🗆 163	∑7740	Specify			Spec	WHI	TE
15. Deceder	nt's Education est grade completed)		16a. Dece	dent's Us	ual Occup	ation during mos	st of work	ing 1	6b. Kind of	Business/In	ndustry
Elementary/Secondary (0-12)	College (1-	-4or 5+)	life.	DO NOT	use retired	d)					
1TH_GRADE			GENE	RAL	CONT	RACTO				EMPL	OYED
7. Father's Name (First, Middle,	Last)							e (First, Middle, Ma	aiden Surn	ame)	
HUGH A. ELLIOT	T, SR.					HA	NNAH	MAE DEYS	HER	_	
9a. Informant's Name/Relations	ship (Type. Print)		19b. Mailii	ng Addres	ss (Street	and Numb	er or Ru	ral Route Number,	City or Tov	vn, State, Zi	p Code)
MILDRED M. ELLI	OTT/WIFE		1647	MUS	SULA	ROAD	TO	WSON. MD	2128	36	
0a. Method of Disposition			lace of Dispo	sition (Na	ame of	1			Oc. Locatio	n - City or T	own, State
1 ☐ Burial 2 X Cremation 4 ☐ Donation 5 ☐ Other (5		state I	TRO CR	-			6/1	1/2009 0	CATONS	SVILLE	, MD
Signature of Funeral Service	·					ss of Facil		- 1	I FINE	CRAL H	IOME, P.A.
and the same of th	MOOL	4	٠	204		DATE					
23 Part Enter the disease, o	r complications that ca	aused the death				RAVE:			SON, I	10 21	Approximate
shock, or heart failure. List	t only one cause on ea	ach line.				3,					Interval Between Onset and Death
mmediate Cause (Final lisease or condition esulting in death)	a. ACUT	E MYCC	ARDI	91 1	NEAL	RCTI	NC				
Journal of Courty	Due to (	or as a consequ	uence of):								
sequentially list conditions,	b									-	
any, leading to immediate ause. Enter Underlying	Dua to (	or as a consequ	ience of):								
ause (Disease or injury nat initiated events	с										
esulting in death) Last	Due to (	or as a consequ	uence of):								
	d										
E EPARAL E					100						
F FEMALE: 23b. Was decedent pregnant		come of pregna pirth 2  Fetal		Tectonic	pregnanc	31/				Date of deli	
in the past 12 months? 1 □ Yes 2 □ No	4 ☐ Pregr	nant at time of d		Other (		, y				Month	Day Year
9 Unknown	9 □ Unkn	own									
art II. Other significant conditi	ions contributing to de	eath but not resu	ulting in the u	nderlying	cause giv	en in Part	i.	23e. Did tob	acco use c	ontribute to	the cause of death?
CEREBRO V.	ASCULAR A	ACCIDE	NT					1 ☐ Ye	2 🗆 No	3 □ Pro	obably 4 V Unknow
								04- 14	104	h Mara aut	tenou findingo ovoilabl
ADVANCED	MOTITATE	SCLER	OPTP_					24a. Was an autopsy perform	·	prior to c death?	topsy findings availab ompletion of cause of
									No	1 🗆 Yes	2 No
5. Was case referred to medical examiner?							e of Dea	th (Check only one	)		
1 ☐ Yes 2 XNo	Hospital: 1 X	npatient 2 🗆	ER/Outpatie	nt 3 🗆 [	OOA Oth	ner: 4□N	lursing H	ome 5 Resider	nce 6 🗆	Other (Spec	cify)
27. Manper of Death	28a. Date	of Injury th, Day, Year)	28b. Time of Injury	of	28c. Injui Wor	ry at		28d. Describe how	v injury oc	curred	
1 Natural 5 ☐ Pendi											

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

25. Was case reaminer? 1 🗌 Yes 27. Manner of D 1 Natural 2 Acciden 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29b. Signature and title of certifie

29d. Date signed (Month, Day, Year) 29c. License number 6 0 D37254

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's fignature 31. Date files (1971) 2 200 TOWSON MARYLAND FR DRIVE 2 2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 1:20 AM reemar 10 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, or Location of Death 4b. City, Town, Examiner Heights Kaltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Year) Months Country 231-36-549 1 M 2 F Virginia Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, it is libited Examination number of the 1 Nes 2 No Director altimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2121 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. . Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ ¥6 Specify: 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Vational 7 is marked other traumatic event, 18. Mother's Name (First, Middle Maiden Surname, 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental Freeman ပ 19b. Mailing Address (Street and Nymber or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau once. Apt 316 Balto. MD 21215 artha Heights reeman Baltimore. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory, or other) Date 20a. Methed of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State Balti more 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign de of Funeral Service Licensee 22. Name and Address of Facility MD 21207 23d. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ONGESTIVE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that infliated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760 physician Physician/Medical the attending pl 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. ed by the a 9 Unknown 9 Unknown signed I 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, à 2 No 3 Probably 4 Unknown 1 🗌 Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 No Vital 2 No 1 ☐ Yes 1 Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 Yes 2 No Hospital: 5 Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To Division of this 27. Manner of Aath 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: /
completely filled in by the fi ∠ □ Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State Registrar

31. Date filed (Month, Day, Year)

29a, Certifier

(Check only

29b. Signature an

Medical

32. Registrar's Signatu JUN 1 2 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day :00 PM **Physician** wetta J HITZ51mmons 2009 June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Elizabeth's Nursing & Rehab Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Jan. 25, 1 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Maryland 89 Director 216-12-2030 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State ns 23a or 28a-f show 1 X Yes 2 □ No Director N/A Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 21227 United States 3320 Benson Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after Never Married 2 ☐ Married th and Mental Hygiene.
7 is marked other than "natural", or it traumatic event, the Wedical Exemi 1 □Yes 2 XNo Specify: White Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Dietician Healthcare 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James A. Fitzsimmons Josephine Cronise မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Salvatore E. Anello III/Nephew 1334 Sulphur Spring Rd., Arbutus, MD 21227 f Health a other t 20b. Place of Disposition (Name of opnetery, stematory or other place)
New Cathedral Date 20c. Location - City or Town, State 20a. Method of Disposition ± ± 5 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department or Important; If any injury or once. 6-12-2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Cemeterv 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Funera 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** angrexia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner leukoc 1+0515 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine Hospital or Attending Physician: The law requires that the death certificate be executed COPD physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, CHFattending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) s been signed by the should be detached 9 Hinknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s performe 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2∐YNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 618109 R111615

State Registrar

31. Date filed (Month, Day, Year)

Baltmare 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ave.

21227

MD

09-04600 Norma Fleming

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		- For State Certificate of Death Reg. No. 2000 1000
Physicia Medical Examir	1177	1. Decedent's Name (First, Middle, Last)  Norma Fleming  2. Date of Death Month Day June 9, 2009  1731 hrs
and the same of		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death  Baltimore
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Age (In yrs. last birthday) 1 If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) 1 M 2 Yrs. Months Days Hours Min. Thu 5, 1948 South Caroline
d d fi.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 No
th the Maryland  23a or 28a-f show	Dire	10e. Street and Number  10f. Zip Code  10g. Citizen of What Country?  21230  USA
hours after death with the Maryland natural", or items 33s or 28s-f she Examiner must be notified at once	Funeral	11. Marital Status 1
	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)
D 21215-0036 should be filed within 72 and Mental Hygiene. 7 is marked other than "ratic event, the Medical	B	17. Father's Name (First, Middle, Last)  Moses Fleming  18. Mother's Name (First, Middle, Maiden Surname)  Helen Mctadden
md 2 and 2 salth:	٢	19a. Informant's Name/Relationship ('ype', Print)  Angelia Fleming - dunghter  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19c. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19c. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19c. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  20b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  20c. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Baltimore permit. Pages 1 a Department of He Important: If it		1 VBurial 2 Cremation 3 Removal from State Crematory or other place) 4 Donation 5 Other, Specify: 21. Signature of Funeral Feylice License:  22. Name and Address of Facility Funeral Feylice License:  23. Name and Address of Facility Funeral Feylice License:  24. The state of Funeral Feylice License:  25. Name and Address of Facility Funeral Feylice License:  26. Name and Address of Facility Funeral Feylice License:  27. Name and Address of Facility Funeral Feylice License:  28. Name and Address of Facility Funeral Feylice License:  29. Name and Address of Facility Funeral Feylice License:  20. Name and Address of Facility
Physician	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approx ate Interval Between Onset and
/Medical Examiner		failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Between Onset and Death  Due to (or as a consequence of):
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause  b. Cocaine intoxication  Due to (or as a consequence of):  c.
760, cate be executed physician and he burial - transit	- 1	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.  XUNPENDED  AMENDED  AMENDED  AMENDED  AMENDED  AMENDED  Due to (or as a consequence of):
	ysician/Medical	FEMALE:   23c. If yes, outcome of pregnancy   23d. Date of delivery   1
h h	ed by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Hypertension  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
Division of Vital Records, P.O tal or Attending Physician: The law requires that transfer death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be dear	Completed	24a. Was an autopsy performed?  1 Yes 2 ✓ No 1 Yes 2 No
Vital ysician: this certiful director	To Be	25. Was case referred to medical examiner?  1 Very 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing Home 5 Residence 6 Other:
ivision of vor Attending Phylifer death. Director: After to his phylifer death.	Certification: T	27. Manner of Death  1 Natural 5 Pending Investigation   28a. Date of Injury (Month, Day, Year)   28b. Time of Injury   28c. Injury at Work?   28d. Describe how injury occurred unk   1 Yes 2 No   28d. Describe how injury occurred unk   1 Yes 2 No   1 Y
Divisospital or A hours after uneral Directly filled in by	Sertific	3 Suicide 6 X Could not be determined Could not be dev
D To the Hospital within 24 hours To the Funeral completely filled	ledical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	Σ	29b. Signature and title of certifier  O.C.M.E.  29d. Date signed (Month, Day, Year)  June 10, 2009
\		30. Name and address of person who completed eause of death (Item 23a)  Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
St Regist	ate rar	31. Date filed (Month, Day, Year)  32. Registrar's Signature
DHMH 17 Rev 1/20	001	ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

			1 - State of Marylan			cate of E		,	Reg. No	0000	3 18923
	Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	Da	ay Year	3. Time of Death
	/Medic		Lily Viola Fritz					June	1	2009	4:25 P <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give street and number)				Location of Death			c. County of Deat	
	Funeral		Arden Court  5. Social Security Number 6. Sex 7. Age (In yrs.	last birthda		Kensine Inder1Year	If Under 24 Hrs.	8. Date of Bi	rth M	ontgomer 9. Birt	hplace (State or Foreign
	Director		579-28-7528 1□M 21X F 81	Yrs.	Moi	nths Days	Hours Min.	(Month, D. October	ay, Year, 12 <b>,</b> 1		uintry) York
	p ,		Usual Residence of Decedent	T	1						10d. Inside City Limits
	aryla shov	'n		y, Town or		1					1 Tyes 2 TNo
	the M	ecto	Maryland Montgomery Ro	ckvi1		If. Zip Code			10a C	itizen of What Co	untry?
	with a or	Funeral Director	15104 Sunflower Court		1,0	20853	1			ted Stat	
	ns 23	nera	11 May Ital Status 12. Was Decedent Ever in U.	S. 13	3. Was [		spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No		14. Race - Ame	rican Indian,
٥	after or ite	Ē	Armed Forces?  1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💆 No			, specity Cubar es 2 <b>X</b> 1No	n, Mexican, Puerto <i>Specify:</i>	Rican, etc.)		Black, White	
2	ours a	d by	3 🕅 Widowed 4 ☐ Divorced If Yes, Give Year or Dates:			es 2 <b>A</b> 1110	эрвспу.		,	Specify: Wh	
212-0036	"natu	lete	15. Decedent's Education (Specify only highest grade completed)	16a. Dei (Gi	cedent's	Usual Occupa of work done di	ition uring most of work	ing	16b. ∤	Kind of Business/	Industry
7	withir ene. than	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	_	ret				Tr	ade Asso	ciation
ם פ	filed Hygi other ent, I	Be Co	17. Father's Name (First, Middle, Last)	000	-100		18. Mother's Name	e (First, Middle	, Maide	n Surname)	
Viand	should be filed within 72 hours after death with the Maryland and Mentel Hygiene. A manural", or items 23a or 28a-f show urratic event, It a Modical Examiner must be rediffed at unatic event, It a Modical Examiner must be rediffed at unatic event, It a Modical Examiner must be rediffed at unatic event, It a Modical Examiner must be rediffed at unatic event, It a Modical Examiner must be rediffed at unatic event, It a Modical Examiner must be rediffed at unatic event, It a Modical Examiner must be rediffed at unatic event, It a Modical Examiner must be rediffed at unatic event, It a Modical Examiner must be rediffed at unatic event, It a Modical Examiner must be rediffed at unatic event, It a Modical Examiner must be rediffed at unatic event, It a Modical Examiner must be rediffed at unatic event, It a Modical Examiner must be rediffed at unatic event, It a Modical Examiner must be rediffed at unatic event, It a Modical Examiner must be rediffed at unatic event, It a Modical Examiner must be rediffed at unatic event, It a Modical Examiner must be rediffed at unatic event, It a Modical Examiner must be rediffed at unatic event, It a Modical Examiner must be rediffed at unatic event at unatic event at unatic event	To B	William Henry Matthes				Gertrud	e Schmi	ldt		
a	shou and N s ma		19a. Informant's Name/Relationship (Type. Print)	19b. Ma	ailing Ad	dress (Street a	nd Number or Rui	al Route Numb	ber, City	or Town, State, 2	Zip Code)
Ξ.	and 2 ealth n 27 i		David Waite/Son				r Court,	Rockvi			nd 20853
ballimore,	Pages 1 and 2 ment of Health a ant: If item 27 is ury or other tra		20a. Method of Disposition 20b. F 1 □ Burial 2 TA Cremation 3 □ Removal from State Met	lace of Dis	position remators	(Name of y or other place 1	June	Pito,		ocation - City or	
	t. Pag tmen tant: ijury		4 □ Donation 5 □ Other (Specify) Cre	mator	У	2 - 0	12007				Virginia
0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If then 27 is marked other than "natural" or items 28a or 28a-f show any Injury or other traumatic event, It a Modical Examiner mast be rediffied at once.		21. Signature of Funeral Service rigensee M01530	H	<sup>22. Nar</sup> Rocky Marvl	ne and Address ville, In and 2085	s of FacilityRobe c. 300 Wes 50	rt A. Pu t Montgo	mphre mery	ey Funeral Avenue	Home/ lockville,
			23a. Part1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line.					or respiratory	arrest,		Approximate Interval Between
F	Physician		Immediate Cause (Final disease or condition Acute Cardio	pu1mo	nary	y Distr	ess				Onset and Death Minutes
j.	/Medical		resulting in death)  Due to (or as a conseq	uence of):							
	Examiner	L	Sequentially list conditions.  Small Bowel		tru	ction					Weeks
	sit ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		nome	2					Months
0	al-tran	xan	that initiated events resulting in death) Last Due to (or as a conseq								110110113
00100	rtificate be executed by physician and as the burial-transit		d								
0	= 0 ~ 1	ledical									
50	attendin for use	J/N	IF FEMALE: 23b. Was decedent pregnant in the decedent pregnant in the decedent pregnant 1 ☐ Live birth 2 ☐ Feta		3 □ Ecto	opic pregnancy				23d. Date of de	-
	he att	Physician/№	1 ☐ Yes 2 ☒ No 4 ☐ Pregnant at time of c			er (specify)				Month	Day Year
	that the denoted by the detached	Phy	9 Unknown  Part II. Other significant conditions contributing to death but not res	ulting in the	undark	ina couca alva	n in Port I	23a Did	tobacco	use contribute to	o the cause of death?
Ď,	signe	þ	Alzheimer's Dementia	ulung in the	undeny	ning cause give	II III raiti.		Yes 2		robably 4 Unknown
colds,	s been signers should be	Completed									
ב ב	e has	du						24a. Was auto perf	psv	prior to	utopsy findings available completion of cause of
2	ifficate	ပိ	25. Was case referred to medical				26. Place of Deat	- /Charle anhe	0 0 0 1		3 2 □No
>	nysician: The is his certificate ha I director, page 2	o B	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2	FB/Outnat	ient 3	DOA Othe	7: 4 Nursing H	n (Crieck only	idence	ASSI	sted Living
5	g P	-	27. Manner of Death 28a. Date of Injury	28b. Time Injury	of	28c. Injury Work	at	28d. Describe	how inju	ury occurred	City
	endin sath. or: Aft he fur	atio	2 ☐ Accident investigation	injury	M		es 2 □No				
2 3	r Aun ter de irecto n by ti	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At he building, etc. (Specification)	ome, farm, :	street, fa	actory, office		28f. Location City or To	(Street a	and Number or R te)	ural Route Number,
ָ נ	urs af									, , , , , , , , , , , , , , , , , , , ,	
3	of the nospital of Attendin within 24 hours after death.  To the Funeral Director; Aft completely filled in by the fur	Medical	29a. Certifier (Check only one)  1 △ Certifying Physician: To the best of my knot and manner stated.	wiedge, de	investig	gation, in my op	ie, date and place pinion, death occui	, and due to the rred at the time	e cause e, date a	nd place, and du	e to the cause(s)
F	To th	Ž	29b. Signature and title of certifier	•		29c. License				ate signed (Mon	
	170		30. Name and address of person who completed cause of death (Iten Jennifer Macalanda, M.D. Natio				al Cente	r. Beth	nesd:	a, Marvl	and 20889
۲	Stat	te	31. Date filed (Month, Day, Year) 32. Egistrac's Signa	ture	-, 20			, 2001		,, -	
	Registra		JUN 1 2 2009 Source	3. 4	Fack	the S				-	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** MERVIN FRIBUSH June 2009 10 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Sinai Hospital of Battimore Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 04/25/1925 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Months Hours Min. 1 □X M 2 □ F 84 216-16-3107 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shot injury or other traumatic event, iha Nectosi Examinar must be notified at Director BALTIMORE MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4721 MARYKNOLL ROAD 21208 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status MERVIN 1 ☐ Never Married 2 ☐ Married 1 XYes 2 THO If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 □Yes 2 🕱 No Specify: þ Specify: 3 X Widowed 4 ☐ Divorced WHITE Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other than College (1-4or 5+) MECHANIC VENDING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SAMUEL **FRIBUSH** BERTHA **JACOBSON** ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other trau 4721 MARYKNOLL ROAD, BALTIMORE, MD 21208 SUSAN THALER / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BNAI ISRAEL 06/11/2009 BALTIMORE, MD 21. Signature of Juneral Service Licenseq 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Congestive Healt /Medical Due to ( f s a consequence of): **Examiner** Myocardia Sequentially list conditions, if any leading to him edicate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 2 No 2 **₩**No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death.
Funeral Director: / investigation 2 Accident 6 Could not be determined 3 Suicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 10d, 12 per fg g892 6-12-09 vt. State of Maryland / Department of Health and Mental Hygiene

:30 AM

Tortes 2 ₺ No

USA

Approximate Interval Between Onset and Death

Year

Day

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

June 10, 2009

Battimore., MD, USA

N/A

MD

within 2

31. Date filed (Month, Day, Year)

TIHOM

29b. Signature and title of certifier

4 Homicide

(Check only

29a. Certifier

GIROTRA, 32. Registrar's Signature

M.D.

Mobile

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

completely filled in by

Medical

State Registrar 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Sinai

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RES- 000.

Haspital

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

		Please Type of amend item 29  1- For Amend Items 28 4 6  Recistrar 25,	Print in led per do of Marylar	G_/8892 G_ <b>e</b> 0889	lelible Ink 6-19-09 2 <b>56/91</b> ificate of	of the and I	II Copie: Mental Hy	ygiene	ble.	18925	
Dhusia		1. Decedent's Name (First, Middle, Last)		0	incate of	Death	2. Date of D	eath	Year	3. Time of Death	
Physic /Med	ical	4a. Facility Name (If not institution, jgive street and r	dug		Dray	- Leastian of Dooth	JUNE	2 5, 20, 4c. County	09 of Doorth	12.00pm	
Funeral Director	*	5. Social Security Number 220–13–0061	7. Age (in yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D	irth (Pay, Year)	9. Birthpla	ace (State or Foreign ry) yland	
		Usual Residence of Decedent					Aug. Z	1, 1911			
with the Maryland a or 28a-f show		10a. State 10b. County  Maryland Harford  10e. Street and Number		10c. City, Town or Location  Aberdeen  10f. Zip Code				10g. Citizen of \	d. Inside City Limits 1 ☐ Yes 2 ☐ No		
h with 23a or	al Di	3738 Aldino Road		21001				USA			
Maryland 21215-0036 Id 2 should be filed within 72 hours after death with the Maryland lith and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show r traumatic event, the Medical Evan in stringled in with death	by Funeral Director	11. Marital Status  12. Was De Armed 1 Never Married 2 Married 1 Never Married 1 Yes, (1)	2 □ No Bive	If Yes, specify Cuban, Mexican, Puerto I				ify Yes or Nocan, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White			
72 hours "natural";		3 ☐ Widowed 4 ☐ Divorced Ye ar or  15. Decedent's Education		16a. Decede	ent's Usual Occup	pation		16b. Kind of Bu			
filed within 72 ho Hygiene. other than "natu	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  2  (Give kind of work done during most of working life. DO NOT use retired)  Defense Contractor  U.S. Go					overni				
be file	Be	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Su					· –	,			
should be and Mental s marked o	2	Robert Lawrence Gray  19a. Informant's Name/Relationship (Type. Print)		19b. Mailing	Address (Street	and Number or Ru		e Bochno		Code)	
and 2 sealth al		Christina L. Gray / Wif	e			Rd., Abei		-	J. 100 100 100 100 100 100 100 100 100 10		
permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 is marked other any injury or other traumatic event, tronee.		20a. Method of Disposition  1월 Burial 2 ☐ Cremation 3 ☐ Removal fror  4☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	n State	Place of Dispos cemetery, cremo rford M	tion (Name of atory or other place emorial Name and Addre CCOMAS F	Gdn 6-1 ss of Facility uneral Ho	Date 10-09 ome, P.	20c. Location - Aberdee A.	n, Ma	ryland	
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is, P.O. Box 6876( es that the death certificate be igned by the attending physicis be detached for use as the bur	edical Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events c.	o (ir as a conseq c (or as a conseq o (or as a conseq	uence of):	(Si)	CERTIFICATION	olon /	Ur AT	651	u, my	
	Physician/Medica	F FEMALE:  23c. If yes, outcome of pregnancy in the past 12 months? 1   Yes 2   No 9   Unknown  23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 4   Pregnant at time of death 5   Other (specify)   Month							y Day Year		
	þ	Part II. Other significant conditions contributing to	death but not res	ulting in the und	derlying cause giv	ven in Part I.		tobacco use cont		e cause of death?	
The law ate has b bage 2 st	Completed							opsy formed?/	Were autop prior to com death? 1 □Yes 2	sy findings available apletion of cause of	
Of VITal Physician: Ti r this certificate ral director, pa	o Be	25. Was case referred to medical examiner?  1 A Yes Hospital:	Innationt 2 🗆	ER/Outpatient	3□ DOA Oth	26. Place of Deat			or (Cassific		
eath. or: After this certificathe funeral director, p	cation: To	27. Manner of D ath    Sample   Sample									
io the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune.	Medical Certification: To	4 Homicide determined 28e. Had buil  29a. Certifler (Check only Medical Examiner: On the	e Injury - At ho ding etc. (Specification of the control of the co	reek /	1001.45	Olcoda?	28f. Location Cround Ground , and due to the rred at the time	1540	rdeen Fiel ood M anner as sta	Proving ds ated. the cause(s)	
To the within 2 To the comple	Me	29b. Signature and title of certifier	OAS		29c. Licens	se number		29d. Date signe フレル と		Day, Year)2009	
		30. Name and address of berson who completed car from the filed (Month, Day, Year) 32.	use of death (Item	て、わと	rint) 4940	Eastern	Ave /	Baltipor	e, MD	21224	
Sta Regist	ate rar	IIIN 1 2 2000	Transital's Gigila	A A	arkel						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month 08 2009 Kimberly George ) une 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shrni Baltimore Washington Medical Center Birthplace (State or Foreign Country) If Under 24 Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Min. Months Hours Days 1 □ M 2 12 F 47 9/23/1961 216-70-3062 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 □Yes 2 X No Annapolis Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21403 116 Pine Crest Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Government Purchasing Agent 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Betty Lou Vickers Christian Fredrick George 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 290-M Hilltop Lane, Annapolis, MD 21403 Patty Templeton/ Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/10/2009 Hanover, Maryland 4X Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature Funeral Service Licensee 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ↑ patient 2 ER/Outpatient 3 DOA

/Medical Examiner signed by the attending physician and d be detached for use as the burial-transi P.O. Box 68760 The law requires that the death Division of Vital Records,

or Attending Physician;

death.

To the Hospital within 24 hours a To the Funeral C completely filled

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**Physician** 

/Medical

**Examiner** 

10a State

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**Funeral** 

Director

28a-f show

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item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Wadical Exeminer must be natified at

permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traun once.

**Physician** 

2 should be filed within 72 hours after on and Mental Hygiene.

Is marked other than "natural", or iter

Baltimore, Maryland 21215-0036

Examine Physician/Medical ğ s peen si Completed page 2 s certificate has funeral director, Be မှ this Certification: After ours after death.

neral Director; A
filled in by the fu

23b. Was decedent pregnant in the past 12 months? ☐Yes 2 No 9 ☐ Unknown

27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 1 Natural 5 Pending investigation 2 TAccident

28d. Describe how injury occurred 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Goden Burnie

29a. Certifier (Check only one)

6 ☐ Could not be

determined

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30)

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar

Medical

3 ☐ Suicide

29b. Signature

4 Homicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Anne Greenberg 11, 2009 2:30 A M June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ellicott City Health & Rehab Howard Ellicott City 9. Birthplace (State or Foreign Country) New York If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funera! Days Hours Min. 1 □ M 2 1 F 90 Yrs 064-01-9217 Sept 24, 1918 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State show r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 1 ☐ Yes 2X No Funeral Directo Ellicott City Maryland Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 3000 North Ridge Road 21043 Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏖 No Specify: White Specify: Completed by 3 ◯ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Dental Hygienist Dental 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jenny Lieberman Isador Goodhart ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) Department of Health an Important: If Item 27 is any injury or other trauonce. 2898 Country Lane Ellicott City, Maryland 21042 Betty Shimshak, Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 06/12/09 Baltimore, Maryland Metro Crematory Inc. permit. 21. Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreshock, or heart failure. List only one cause on each line. Alhero celeratic Cardio Vascular Diper Immediate Cause (Final disease or condition resulting in death) **Physician** Pulmonory Dixease /Medical Examiner betructive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 Other (specify) P.0 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 4 Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 □Yes 2 No 1 TYes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After th funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Tecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier D 30641 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Romesh Sabapathi 201-109 Back River Neck Road Baltimpre Morgland 2122

DHMH 17 Rev 1/2001

State Registrar

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Kudolph PM 7:15 06 09 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner 121 St. Agnes Lane Social Security Number 6. Sex Baltimore Apt. 326 If Unde Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F Months Days Hours Min 237:50-1663 9-4-32 Director Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examination in the free rectine 1 at 1 Yes 2 □ No Director Baltimore mD 10e. Street and Number 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Hanes Lane 21207 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Specify. 3 Widowed 4 □ Divorced Specify: BIK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wit Department of Health and Mental Hygien. Important: If item 27 is marked other the any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code) ္ဝ 19a. Informant's Name/Relationship (Type. Print) Evely Skeete

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 130 th Street Apt. 1A +. IA NewYorKNY 10027
20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 6/18/09 breen mount 4 ☐ Donation 5 ☐ Other (Specify) rematory 22. Name and Address of Facility Laugh Funeral Services 21. Signature of Funeral Service Licensee . Grane Baltimore 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** GENERAL MONTH disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): requires that the death certificate be executed and Due to (or as a consequence of): burial-Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery Year ' 3 - Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by sign be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has page 2 autopsy performed After this certificate I funeral director, page 1 ☐Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 X ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending n 24 hours after death.

e Funeral Director: Af 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD @ 15109 D45274 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21228 MD Che Maung
31. Date filed (Month, Day, Year) 516 3. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#20b, c. perFH, G892, 6/17/09, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** REEN 6:12 2009 HNE /Medical 4a. Facility Name (If not institution, give street and дирьег) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAL TIMORE QURS HOSPITA 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Min 1 M 2 □ F Months Days Hours Director 225206779 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at 1 Ves 2 □ No Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or Pages 1 and 2 should be filed within 72 hours after death with 21229 USA 706 Was Decedent Ever in U.S. Armed Forces? or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Newer Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑No Specify. ð Black 3 ₩Widowed 4 □ Divorced than "natural", Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: if item 27 is marked other than "rany injury or other traumatic event, ir a May once. College (1-4or 5+) oreman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ George Green 19a. Informant's lene/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 706 Wicklow lacqueline Kwanna <u>Uhugh</u> Ho MI) 20c. Location - City or Town, State Crownsville, MD 20b. Place of Disposition (Name of 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Balso. MD 2100 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARDIOV **Physician** /Medical Due to or as a consequence of): Examiner STAG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Division of Vital Records, P.O. Box 68760, attending physician for use as the burial IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐ Yes 2 100 Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann eath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No hin 24 hours after death. 2 Accident filled in by the 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. within 7 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 2009 (Item 23a) (Type, Print) 30. Name and address of person whe completed cause of death 0 31. Date filed (Month, Day, 32. Registrar's Signature Year State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🖺 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death AM **Physician** ANDREW /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner HOSPITAL BALTIMORE MEMORIAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 M 2 □ F 214-64-6506 3 DCTOBER 19,1955 MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show 1 and 2 should be filed within 72 hours after death with the Maryla Health and Mental Hygiene.

em 27 is marked other than "natural", or items 23a or 28a-f show ther traumatic event, the Medical Examination and the modified at 1 Yes 2 □ No BALTIMORE Director MARYLAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 507 E. Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 MYes 2 No If Yes, Give Dec 5,1973 Year or Dates: FeB 18,1977 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK 2 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MACHINIST YEARS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be GREEN A. GEORGE ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) VERONICA TAYLOR GREEN (WIFE) 507 permit. Pages 1 and Department of Health Important; if item 27 any injury or other tr. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 MaCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CREMATORY Ob/10/2009 BALTIMORE, MARYLAND 22. Name and Address of Facility
SOSEPH H. BROWN JR. FUNERAL HOME
2140 N. FULTON AVE, BALTIMORE, MD 21917 21. Signature of Funeral Service Licensee Vuamo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final distruction **Physician** Chronic Biliany 3month disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 2month Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐Yes 2 ☐No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 1 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has autopsy performed 2 10No 1 ☐ Yes Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifice filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manuer of Death 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 / Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 ☐ Homicide within 24 hours a

To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) title of certifie 29c. License number 29b. Signature and 80. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar

DHMH 17 Rev 1/2001

09-04350

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 18931

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Past 12 months?	eath certife strength		22h Was decedent pregnant in the	anancv	No. 15 Day Vos						
29b. Signature and title of certifier  O.C.M.E.  June 1, 2009  30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			past 12 months?  4 Pregnant at time of death 5 Other (Specify)	5Ediopio pro	gridiney	- 1					
29b. Signature and title of certifier  O.C.M.E.  June 1, 2009  30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201		<u>s</u>			100	2:43-5		a to the source of death			
29b. Signature and title of certifier  O.C.M.E.  June 1, 2009  30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			Part II. Other significant conditions contributing to death but not resulting in the underlying cause		1 Yes 2 No 3 Probably 4 Vunknov						
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29b. Signature and title of certifier  O.C.M.E.  June 1, 2009  30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201		Bel			<del>-</del>	performed	deat	h?			
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29b. Signature and title of certifier  O.C.M.E.  June 1, 2009  30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201		악	1 V Yes 2 No								
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29b. Signature and title of certifier  O.C.M.E.  June 1, 2009  30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			Homicide determined (Specify)								
29b. Signature and title of certifier  O.C.M.E.  June 1, 2009  30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s)								
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Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			29b. Signature and title of certains			J	lune 1, 2009				
Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			COOLER								
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature				imore, MD 21	201						
	Stat	te									

09-04535 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2009 18932 Kenneth Anthony Gajewski State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ June 7, 2009 Medical Examiner 1754 hrs Anthony Kenneth Gajewski, Jr. 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 545 45th Street Harbor View **Baltimore County** 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number If Under 24Hrs. 6. Sex If Under 1 Year **Funeral** 7. Age (In vrs. last birthday) Foreign Months Hours Days Director 212-19-8441 29 Oct, 12,1979 Country) MD 1X M Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location Yes 2 X No or items 23a or 28a-f show must be notified at once. Baltimore Maryland Edgemere Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9000 Avenue A United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Forces 1 X Never Married 2 Married XX No Yes 2 No specify: White If Yes, Give Year Specify Yes Widowed Divorced the Medical Examiner ģ ore, MD 21215-0036 ges 1 and 2 should be filed within 72 hours of Health and Mental Hygiene. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Ped plet Elementary/Secondary (0-12) College (1-4 or 5+) 12 Years Com Factory Worker Plastics 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) marked or other traumatic event, Be Kenneth A. Gajewski, Sr. Maureen Sav 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) tant: If item 27 9000 Avenue A Mrs. Maureen Gajewski (Mother) Edgemere, Maryland 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 6/12/2009 Donation 5 Other Specify Rosary Cemetery Baltimore, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Part I. Enter the disea **Physician** Between Onset and failure. List only one cause on each line /Medical Methadone intoxication Immediate Cause (Final disease 'xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Exami lige (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit AMENDED #1 as noted, 23a,27,28a-f,per ME G892 6/29/09 Physician/Medical XUNPENDED the attending physician a sed for use as the burial -Division of Vital Records, P.O. Box 68760, Ital or Attending Physician: The law requires that the death certificate by IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Day Live birth 3 Ectopic pregnancy Month Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify cate has been signed by the attr page 2 should be detached for 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 ✓ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 1 V Yes 2 No certificate 26.Place of Death (Check only one) funeral director, 25. Was case referred to medica Be examiner? Hospital: 1 Residence 6 V Other: Scene ER/Outpatient 3 Nursing Home 5 this Inpatient 2 1 ✔ Yes ဥ 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death 28b. Time of Injury Certification: Natural Yes 2 X No death. neral Director: Pending Fd 6/7/09 Fd 5:48 pm 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 545 45th St. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be 3 Suicide found at residence determined To the Funeral Harbor View, Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 Medical 2 Wedical Examiner: Or the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) nd manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and fitte d O.C.M.E. June 8, 2009 completed cause of death (Item 23a) 30. Name and addre OCM Mary G. Ripole MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 2 2009 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 28b per me, g892,06/II/09dhb

Certificate of Death

Reg. No. For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** IZABETH HENDERSON ///5 05 2008 27 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner OF MARYLAND MEDICAL CENTER BACTIMORE WIN If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 2/20/1916 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🔀 F Hours Months Days 93 Director Maryland 218-40-0952 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show of Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-1 shov other traumatic event, I'm Medical Evan it are must be notified at 1 ☐ Yes 2 🛣 No Director MD. Harford Jarrettsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 1109 Baldwin Mill Road 21084 United States **Funeral** 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2**X**□No Specify. Completed by Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Chenworth C. ပ Harry Rebecca Scarff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) R. Allen Henderson /Son P.O. Box 35 Jarrettsville, Maryland 21084 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/30/2009 Madonna, Maryland Bethel Cemetery 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility E.G. Kurtz & Son Funeraal Home, P.A. Jarrettsville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a PNEWNO THORAX DUE TO FALL disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** 30 MINUTES SPIKATORY FAIRURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (u) as a consequence of): Examine 2 DAYS FRACTURES Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical FALL attending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant CERTIFICATION APPROVED BY MEDICAL Month 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2XNo signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CHRONIC OBSTRUCTIVE PULMONARY 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has t irector, page 2 s autopsy CARDIAC DISEASE perform 1 ☐ Yes 2 ☐ No 1∐Yes 2∭XNo director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1XYes 2 □ No 1' Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury s after dea... cal Director: Aft 05/25/2009 FELL DOWN STATES **Unknown**<sup>M</sup> 1 ☐ Yes 2 XNo 2 Accident 6 Could not be determined 3 Suicide n 24 hours after de le Funeral Directo bletely filled in by ti 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)//09 84 DULL RD. 4 ☐ Homicide HUME JARCETTSVILLE MD 21084 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical within 24 ho

To the Fune

completely f (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NASRALLAH, 22 S. GREENE ST BALTSMORE 21201

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JUN 1 2 2009

32. Registrar's Signature

09-04596 Virginia Howell		Please Type or Print in Black Indel State of Maryland / Departm			ole.	
.0			ate of Death	Reg.	$_{No.}$ 2009	1893
Physiciar Medical Examin	n/ er	Virginia Howell		2. Date of Death  Month Da  June 9, 2009	ay Year	3. Time of Death 1618 hrs
		ia. Facility Name (if not institution, give street and number)  94 Hollingsworth Manor	4b. City, Town, or Location of Death Elkton		4c. County of Death Cecil	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bir $50-34-9985$ $1\square$ M $2\cancel{R}$ F	hday) If Under 1 Year If Under 24Hrs Months Days Hours Min.  Yrs.	8. Date of Birth (No. 1) Dec. 5.	MM/DD/YYYY) 9. Birth Foreign Cour	place (State or Penns Grove htry)
vith the Maryland s 23a or 28a-f show any e notified at once.	ō	Journal Residence of Decedent  10a. State 10b. County 10c. City, Town  CECI 10c. Street and Number 10c. Street and Number 10c. Street and Number 10c. City Nove 10c. City N	Elkton 10f. Zip Code	10g.		10d. Inside City Limits 1 Yes 2 No
s after death v ral", or item	by Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No 1 Widowed 4 Divorced If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto  1 Yes 2 No specify:  Decedent's Usual Occupation (Give kind of v	Rican, etc.)	14. Race - Americ White, etc.  Specify:   (	ack_
5-0036 led within 72 hou Hygiene, other than "nat the Medical Exa	ompleted	Elementary/Secondary (0-12)  College (1-4 or 5+)  7. Father's Name (First, Middle, Last)	during most of working life. DO NOT use reting the state of the state		Jursing den Surname)	Home
1215- I be filed ental Hyg arked of	Be C	Alex Moore Sr	Alice	Good	win _	
MD 2. td 2 should the and M m 27 is m.	욘	19a, Informant's Name/Relationship (Type, Print) William B Howell III - Husbard C	b. Mailing Address (Street and Number or P P4 Hallings Worth A	Janor, E	IKton, MI	21921
			of Disposition (Name of cemetery, lory or other place)  Side Cemetry (6)	Date 2	Oc. Location - City or T Woodstow	own, State
Balti permit. Departm Importa		2 Signature of Funeral Service Licensee	22. Name and Address of Ficility Ho	Well i	Falto N	Home 10 21207
Physician /Medical Examiner		Part I. Enter the disease, or complications that caused the death. Do n failure. List only one cause on each line.  Immediate Cause (Final disease     Atherosclerotic Cardiovascu		r respiratory arrest	shock, or heart	Approximate Interval Between Onset and Death
		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.				
5-9	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated				
ecuted and transit	_	events resulting in death) Last  Due to (or as a consequence of):  d.			_	
0, the ext	edic	UNPENDED				
Box 68760, re death certificate be exect the attending physician an ed for use as the burial - u		Pregnant at time of death	Fetal death 3 Ectopic pregnation of their (Specify)	ancy	23d. Date of delivery Month D	ау Үеаг
P.O. Bosthat the degened by the seed etached for	의	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part I.		cco use contribute to t	he cause of death?
n of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by thereral director, page 2 should be detach.	Completed t			24a. Was an autopsy performs	24b. Were aut	opsy findings available ompletion of cause of
Rec : The ificate r, page		25. Was case referred to medical	26.Place of Death (Check	1 Yes 2	✓ No 1 Yes	2 No
/ital	m۵	eyaminer?	104		esidence 6 🗸 Other:	Scene
of \ng Ph	일	27. Manner of Death 28a. Date of Injury (Month. Day Year)	Time of Injury 28c. Injury at Work?	28d. Describe how	v injury occurred	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	ertification	3 Suicide Could not be determined (Specify)	1 Yes 2 No No larm, street, factory, office building, etc.	28f. Location (Stre or Town, Stat	eet and Number or Rur e)	al Route Number, City
n 24 hou e Funer	ledical Ce	29a. Certifier 1 Certifying Physician: To the best of my knowledge, decone)  2 Medical Examiner: On the basis of examination and/or	eath occurred at the time, date and place, and	d due to the cause(s	s) and manner as state	d. e cause(s)
To the within To the comp	Medi	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mon	
		Theoden Mi Kring Thy men 30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.	OCME	June 10, 2009	
		Theodore M. King, Jr., MD. Assistant Medical Exam	niner 111 Penn Street, Baltimor	re, MD 21201		
Sta Regist	ate rar	31. Date filed (Markh, Day, Year) 2009 Registrar's Signaffre	park			

DHMH 17 Rev 1/2001 OCME 2006

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** MAMIE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner General Baltimore Maryland
5. Social Security Number Date of Birth (Month, Day, arch 5 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Year) Days Hours Min. 3-36-6939 1 M 2 M March Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Event increase to context. 1 Nes 2 No saltimore Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2121 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 2 No 1 ☐ Neyer Married 2 ☐ Married 1 □Yes 2 🛂 No Specify: Back Specify: Completed by 3 ₩idowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ္ Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rura) 19a. Informant's Name/Relationship (Type. Print) Ksonneice 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ▶ Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Baltimore, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Balto MD2126 23d. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final asa **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner noch Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed Exami the burial-tra Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) P.0. been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performe certificate I 2 No 2 🗆 No 1 □ Yes Division of Vital After this certification funeral director, I 25. Was case referred to medical exampler? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation in 24 hours after death.

In Funeral Lirector After the fundetely filled in by the fundetely filled in 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of gerson who completed cause of death (Item 23a) (Type, Print) LUBEIL 410 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Frederick Leroy 3:45 PM Haslup june 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospital Balkmore Baltmore Agnes If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 X M 2 □ F 215-12-4166 Director 87 JUN 16, 1921 Maryland Usual Residence of Decedent with the Maryland 10b. County 10a, State 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 ☐Yes 2 No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1226 Maiden Choice Lane 21229 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 177 Yes 2 □ No If 16s, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 <u></u> 1 ☐Yes 2 No Specify 3 ₩Widowed 4 Divorced Specify: White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, Ins. Ma. College (1-4or 5+) Elementary/Secondary (0-12) **Painter** Home Improvement Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Unk. ပ Haslup Unk. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith A. Martin, daughter 1226 Maiden Choice Lane Baltimore, MD 21229 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory, Inc. 06/10/09 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility Cremation Society of MD, Inc. 21. Signature of Funeral Service Licensee George MacNabb 299 Frederick Road Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocaleu Physician Day disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner oronali Ecquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 🗆 Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ icate has been signal, page 2 should b Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 X No 1 □Yes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 27 No Certification: To this 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After t 28h Time of 28d. Describe how injury occurred Natural 5 Pending investigation n 24 hours after death.

Ne Funeral Director: A pletely filled in by the fu 1 ☐ Yes 2 Accident 2 No 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2.

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

1 2 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -odelu

Caron

900

32. Registrar's signatu

20965

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2009 9, 4:05 PM **Physician** June John Nelson Harvey /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 510 Academy Road Baltimore Catonsville 8. Date of Birth (Month, Day, Aug 19, 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 1950 **Funeral** Days Hours 1**X** M 2□ F 58 Maryland Aug 215-58-1581 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, I'm Mc Jean Everings must be seen any injury or other traumatic event, I'm Mc Jean Everings must be seen. 10d. Inside City Limits 10c. City, Town or Location 10h. County 10a. State 1 ☐ Yes 2 No Catonsville Funeral Director Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 21228 USA 510 Academy Road 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Northrupp Grumman Electricial Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary V. Campbell Charles N. Harvey ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 510 Academy Road Catonsville, Maryland 21228 Dorothy B. Harvey, Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 06/13/09 Woodlawn Cemetery <sup>22</sup> Name and Address of Facility Home, P.A. Mac Nabb Funeral Home, P.A. 299 Frederick Road Catonsville, Maryland 21228 21. Signature of Funeral Service Licensee Thomas Gregor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final yeur Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed attending physician and for use as the bunal-trar Due to (or as a consequence of): P.O. Box 68760; Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐Yes 2 ☐ No 5 Other (specify) ed by the detached 9 I Unknown 9 Unknown s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ⊌nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed? 1 ☐ Yes 2 ☑ No certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending investigation 1 □Yes 2 □No 2 Accident filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature D30185 June 10, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road Suite 210, Cutarsville MS 20218 Frederick 405 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month June 9,2009 5:00P Virginia Hanratty 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Harford Bel Air 1301 Saratoga Drive If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) December 19,1919 West Virginia 5. Social Security Number Months Days Hours 1 □ M 2 🗓 F 234-20-5273 89 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Harford BelAir Md. 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code USA 21014 1301 Saratoga Drive 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2**X** No White 1 ☐ Yes 2 【No Specify: Specify: 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home <u>Homemaker</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ella Suiter John R. Baker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tim Hanratty 1301 Saratoga Drive BelAir, Md. 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-12-2009 Harford, md. Bel Air Memorial Schimunek Funeral Home 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 610 W. Mac Phail Rd. BelAir, Md. 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) 007 14 if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) 9 ☐ Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed Yes 2 No pertension 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. as case referred to medical examiner?

**Physician** /Medical Examiner

Physician

/Medical

Examiner

**Funeral** 

Director

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Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
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permit. Pages 1 and Bepartment of Health Important: If item 27 any Injury or other troone.

altimore, Maryland 21215-0036

Director

Funeral

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Completed

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P.O. Box 68760,

Division of Vital Records,

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filled in by the

Examiner Physician/Medical þ Completed Be Certification: To funeral ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After ti

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 Unknown

2 X No

1∐ Yes

27. Manner of Death

Natural

2 Accident

4 Homicide

3 Suicide

29a. Certifier (Check only

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28a. Date of Injury (Month, Day, Year) 5 Pending investigation

6 ☐ Could not be determined

28b. Time of 28c.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Blod, White Mark, MD 21236

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number 127230 29d. Date signed (Month, Day, Year)

State Registrar

Medical

31. Date filed (Month, Day, Year) **JUN 12** 

CUTLER

Registrar's Signature

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09-04418	
Joseph Hunt	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Joseph Hunt		State	of Maryland		rtment of tificate of		and	Menta	al Hygiene			2.0	00	00'
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Medical Examir		Joseph	1	r		Hun	<b>t</b> .т	r	Month		Day Yea 9	ır	0739 hrs	3
4		4a. Facility Name (if not institution, gi	ve street and number)		4	Hun b. City, To		ocation of	Death		4c. County of	of Deat	h	
·		407 Eastlynne Avenue				Baltimo						1	<del> </del>	
Funeral		5. Social Security Number 6. S		e (In yrs. la	ast birthday)	If Under Months	_	If Under Hours	24Hrs. 8. Date	of Birth (	(MM/DD/YYYY	9. Bi		or
Director		216-62-6786 1	XM 2 F	53	Yrs.		Buyo		03	02	56	Co	ountry)	MD
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221 hould I nd Mer is man	유	Joseph L. Hun  19a. Informant's Name/Relationship			19b. Mailing	Address	(Street a	and Numb	er or Rural Rout	e Numb	er, City or Tow	n, Stat	e, Zip Code)	17
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Hutchins, George Bryant
09-04139

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State of Mary	vland / Departmen	t of Health and	Mental Hygiene

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any	F	Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or L	ocation				10d. Inside City Limits
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Maryland 28a-f show	왕	10e. Street and Number		<u> </u>	10f. Zip Co	de	10g	. Citizen of What Co	untry?
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Baltimore, permit. Pages I an Department of He Important: If ite		21. Signature of Funeral Privice Line on a ld S	Wade, Direct	or	22. Name and Ad State An Baltimor	dress of Facility atomy Boa e, Maryla	rd 655 We	st Baltimo	ore Street
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a. Certifier 1 Certifying Phy	sician: To the best of my kno iner:On the basis of examina	owledge, death	occurred at the ti	me, date and place,	and due to the cause	e(s) and manner as s	stated.
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		11 - 00	PM. 00			D.C.M.E.		May 25, 2009	
		30. Name and address of person w	to completed cause of death	(Item 23a)					
			Assistant Medical Exa		11 Penn Stre	et, Baltimore, N	MD 21201		
St	ate	31. Date filed (Month, Day, Year)	32. Registrar's S	ignature					
Regist			00 /2	1. 160	alle				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Shirley Hagner June 7:20 A<sup>M</sup> 9, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 1907 Eastfield Road Dundalk Baltimore Co. 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□ M 2 F Months Days Hours Min 213-50-9332 Yrs Director 79 Maryland 10, 1929 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I've Medical Examiner must be martined. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes XXNo Director Dundalk Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 1907 Eastfield Road Funeral United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. þ Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation. 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Helen Osborne Rudolph Peters ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7862 Rockbourne Road Dundalk, Maryland 21222 Mr. Michael D. Hagner (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Hilltop Service Corp. 6/12/2009 Towson, Maryland 4 Donation 5 ☐ Other (Specify) Signitury of uneral Service Luc 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** onces /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, 🛪 attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) the ☐Yes 2☐No 9 🗌 Unknown 9 Unknown I signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2.000 certificate 1 ☐Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After 1 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation eral Director: / 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours at To the Funeral D completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and fittle of certifie 29d. Date signed (Month, Day, Year) 024356 June 9, 2009

State Registrar 30. Name and address of person who con

Frankling Square Dr. Baltimore MA 21237

Het cause of death (Item 23a) (Type, Print)

William

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 28a-f per me,g892,06/11/09dhb Certificate of Death Reg. No. For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ocial Security Number If Under 1 Year | If Under 24 Hrs. | 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day) 9. Birthplace (State or Foreign Country) **Funeral** 1 M 2□ F Months Days Year Hours Min 42 Yrs. Director Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evar in must be notified a once. Yes 2□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21202 Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: Specify: 3 Widowed 4 Divorced Dlace Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) pervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ TO WOY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip,Code) Beatrice Sister Shettield Koag Dummers 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State WMAS Mills 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SCHITMUTE Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): CERTIFICATION APPROACH BY MEDICAL EXAMINER Physiclan: The law requires that the death certificate be executed Exami I physician and sthe burial-trans resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical cate has been signed by the attending p page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ğ Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an autopsy performed? Yes 2.2.No certificate Division of Vital 1 □ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐Yes 2☐No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this completely filled in by the funeral e Hospital or Attending P 24 hours after death. Funeral Director: After t 27. Manner of Death 28a. Date of Injury 28b. Time of p 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 05/31/2009 Unknown M 2 Accident investigation 1 □ Yes 2 X No Subject used cocaine Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1422 Holbrook Street 4 Homicide Home Baltimore,MD 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only To the I within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #8 per HF G892 6/12/09 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 Physician Day 12:58 AM arie onnson /Medical County of Death Facility Name (If not justitution, give street and number) 4b. City, Town, or Location of Death **Examiner** Genesis Randallstown Nursing Home Kandallstorm, 1 Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1906 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2√2 F Director 103 01 01 06 MD 218-26-4723 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 XYes 2 □ No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2452 Woodbrook Ave 21217 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Black 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Housekeeper Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Skinner Nellie Harrod 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Whitfield-Guardian 5525 Belleville, Ave, Baltimore, Md 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland National 6/16/09 Laurel, Md 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21215 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ercbral Vascular accident day disease or condition resulting in death) /Medical Examiner erebral Vascular ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physlcian: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician a Physician/Medical as for use IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) ed by the a detached f 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has autopsy performe 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pendina death. investigation 1 🗌 Yes 2 No 2 Accident hours after death uneral Director: the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BFTH A. NHITEFORD CRM 9109 M. WHITEFORD . 910 -1601 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar
DHMH 17 Rev 1/2001

amend Tease Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 3:48<sup>a.M</sup> Olive E. Jackson 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore
If Under 1 Year | If Under 24 Hrs. Future Care N/ADate of Birth (Month, Day, Year) 12-17-1935 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Months 219-30-2941 Director MD 73 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ir than "natural", or items 23a or 28a-f shov Yas 2 □ No Director MD N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1514 Retreat Street Pages 1 and 2 should be filed within 72 hours after death whent of Health and Mental Hygiene.
snt: If Item 27 is marked other than "natural", or items 23: by Funeral 21217 U S A 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 XNo Specify Specify: Black 3√ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) llth grade Private Duty

18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Edges Mary Robinson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health a Important: If Item 27 is any injury or other trau once. Samuel Knight-Son 1514 Retreat Street Balto, MD 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest 6-17-2009 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March East F/H 21202 ware 1101 E. North Avenue Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** NA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause Observed or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, ned by the attending physician detached for use as the buria IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed this certificate 1 ☐ Yes 2 No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: A Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA hours after death.

neral Director: After this y filled in by the funeral di Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 6 To the Hospital within 24 hours a To the Funeral L Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Britima, Mp. 2120 BYDL MILLION 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

Amend PI line a-b. PII Per ME G892 6.29.09 TT Please type of Print in Black dadelible in Ensure All Copies Are Legible. Items 27,28a-f per me, g892,06/II/Osline Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 25 per dvr/me, g892,06/I0/09dhb

Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death JUNE **Physician** 2009 03 05:28P M HANNA KATZ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE PIKESVILLE SUNRISE ASSISTED LIVING 9. Birthplace (State or Foreign Country) MD 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 08727/1911 1 □ M 2 □ F 97 Yrs. 216-46-2910 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, "In "Multial Eventive I must be notified at aggree. 10d. Inside City Limits 10c. City, Town or Location 10a, State 10h County 1 ∐Yes 2 📉 No Director BALTIMORE BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 SLADE AVENUE, #615 21208 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: WHITE þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ROSE NEEDLE ISAAC NEEDLE ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4108 WINDRIDGE ROAD, BALTIMORE, MD 21208 KITTY CAPLAN / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ YBurial 2 ☐ Cremation 3 ☐ Removal from State ANSHE EMUNAH 06/05/2009 BALTIMORE, MD Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Signature of Funeral Service 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Head iniury Approximate Interval Between Onset and Death Head injury Immediate Cause (Final Physician l3 days disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 13 davs fall RESTRICTION APPROVED BY MEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be execute that initiated events resulting in death) Last Due to (or as a consequence of): tten fing physician a for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 9 Unknown certificate has been signed by rector, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Humeral Fracture, hypertens, or, dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? osteppororir, chronic performed Sich sinus syndrome 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 A Yes 2500 director, Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASSISTED Medical Certification: To 28a. Date of Injury
(Month Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year 05/21/2009 approx. 10:30 a. ospital .
4 hours after dea..
-ral Director: Aft 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 X No Fall from standing 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Assisted Living Facility 28t. Location (Street and Number or Rural Route Number, City or Town, State) 3800 01d Court Rd. Pikesville, MD الم 24 hou. "Ye **Funeral Di.** الا filled in by determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Karen J. Belitt, MID. D58676 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 Karen L. Boyitt, M.D. 700 ad wort load rute 301 Baitmore 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

JUN 1 0 2009

Faved to ME

Amend Items

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 12:33 PMM 9, 2009 June David Elgert Klingaman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 12/22/1931 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 150 M 2 □ F 77 Director PA 215-28-4383 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinat must be notified at 1 ☐ Yes 2 🕱 No Director MD Bethesda Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20817-Funeral 6530 Democracy Blvd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 þ 1 □Yes 2 🗷 No Specify: White 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ges 1 and 2 should be filed within t of Health and Mental Hygiene. If item 27 Is marked مئك. Engineering Elementary/Secondary (0-12) College (1-4or 5+) Naval Architech 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maurine Elgert Dantzic Foster Ellis Klingaman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kim Viti Fiorentino/Guardian 11921 Rockville Pike Rockville, MD 20852permit. Pages 1 a
Department of He
Important: If Item
any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Jun 15 Brentwood, Maryland 4 □ Donation 5 ☐ Other (Specify) 2009 Fort Lincoln Cemetery 21. Sim alu e Funera S rvice Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Services mo0982 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Aspuration. Preumonie 12 days /Medical Due to (or as a consequence of): Examiner yeurs SEVERE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of attending physician and for use as the burial-tra Due to (or as a consequence of): 333 Box 68760, requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached Ö 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed? certificate Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No dir 1💢 Inpatient Certification: To 2 ER/Outpatient 3 DOA ō this s after death.

I Director: After this id in by the funeral d 27. Mapner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Di completely filled in 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) md Rockville ARAJVANSILI MD Congressional # 409 31. Date filed (Month, Day, Registrar's Signature Year}- -State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Isidore Francis Klein 7:00 PM 8, June 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 131 Covered Wagon Road Middle River Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Month, Day, Year) March 20, 1937 Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 XM 2 ☐ F 213-80-1982 72 Massachusetts Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits Department of Health and Mental Hygiene. Important; if item 223a or 28a-f show amportant; if item 27 is marked other than 'natural', or items 23a or 28a-f show ampling or other traumatic event, the Medical Excition country of the property of the contract 1 ☐ Yes 2X No Director Middle River Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 USA 131 Covered Wagon Road by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎾 No Specify: White Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Care Provider Basic 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Klein Loretta Samsel 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 131 Covered Wagon Road Middle River, Maryland 21220 Thomas F. Tyree, Domestic Partner 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc. 106/09/09 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Physician Myelogenous one month disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-transit be execute Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 1 □Yes 2 □No cate has been signed by the page 2 should be detached it 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Obstructive Kulmonary 1 √ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe this certificate 1 ☐ Yes 2 **2** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1∏Yes 2DNo Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Division of Vital Records, P.O. Box 68760,

spital or Attending Physician: Theoris after death.
neral Director: After this certificate y filled in by the funeral director, pa Hospital of 24 hours a To the Hospital within 24 hours a To the Funeral C completely filled

> State Registrar

29a, Certifier

29b. Signature and title of certifie

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To certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) Type, Print)

and manner stated.

32. Registrar's Signature

31. Date filed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 848A M 2009 Gary Paul Kilmer JUNE 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Prince Georges Doctors Community Hospital Lanham If Under 1 Year If Under 24 Hrs. 8. Date of Birth Manufus Min. (Month, Day, 5. Social Security Number 6. Sex 1 M 2 □ F 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Days Months Jan 21, 1964 Maryland 218-86-4062 45 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Greenbelt Prince Georges MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20770 USA 8210 Mandan Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: white If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry unk 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) electrician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul Samuel Kilmer Jr. Dawn Pollard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15795 Valley Avenue Blue Ridge Summit, PA 17214 Meredyth A. Shaw/sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) In State 22 Name and Address of Facility State Anatomy Board 655 West Baltimore Street Raltimore, Maryland 21201 21. Signature of Funeral 21 Virgetor 23a. Part 1. Enter the disease of complications the shock, or heart failure. List only one cause Approximate Interval Between Onset and Death aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, n each line Immediate use (Final disease or condition resulting in death) Iver (or as a consequence of): Due t Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions conditions to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 🌠 Probably 4 🗍 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Ory 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient 2 ER/Outpatient 3 DOA

**Physician** /Medical Examiner Examine burial-tran

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27. Manner of Death

2 Accident

3 Suicide

29a. Certifier (Check only

4 Homicide

29b. Signature and title of certifle

5 Pending

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investigation 6 ☐ Could not be

determined

Medical Certification: To

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artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the Medical Examinar must be no fifted at

Baltimore, Maryland 21215-0036

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/Medical

law requires that the death certificate be execu

Division of Vital Records, P.O. Box 68760, Hospital or Attending

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day, Year)

29c. License number 525 00

28c. Injury at Work?

1 ☐Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

118 GOOD LUCK RUAD LANHAM, MUDOTOG FOZIA ABDULL 31. Date filed (Month, Day, Year) HABE 82. Registrar's Signature

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Maria Kaczmareck State of Maryland / Department of Health and Mental Hygiene 2009 18950 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2 Date of Death 3 Time of Death June 10, 2009 Medical Examiner 1215 hrs MARIA KACZMAREK 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 2205 Bank Street Baltimore N/A 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign **Funeral** Country Months Davs Hours Director 02/27/1919 218-46-5975 1 M 2 X F 90 Yrs UKRAINE Usual Residence of Decedent 10c. City, Town or Location Ę 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No 28a-f show BALTIMORE MD N/A notified at once. Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
snt: If item 27 is marked other than "natural", or items 23a or 28a-f she Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2205 BANK STREET 21231 U.S.A 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 Never Married 2 Married 1 Yes 2 X No 3 X Widowed 1 Yes 2 X No specify: 4 Divorced f Yes, Give Year WHITE event, the Medical Examiner Specify: 含 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) CLOTHING SEAMSTRESS 8 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) WASYL ADAMANETZ UNKNOWN 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAN KACZMAREK/ SON 802 DELLWOOD DRIVE, FALLSTON, MD 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State Itimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State ST. MICHAELS UKRAINIAN 6/13/09 BALTIMORE, MD 4 Donation 5 Other Specify 21. Signature of Fund San Hame and Address of Earlity ER 901 EASTERN A ER INC. FUNERAL HOME AVENUE, BALTIMORE, MD 21231 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and /Medical Death a, Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and ed for use as the burial - tran Physician/Medical #1 as noted per ME g892 6/15/09 TT X AMENDED UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> 1 Yes 2 No 3 Probably 4 V Unknown Completed this certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed Yes 2 V No Yes 25. Was case referred to medical 26.Place of Death (Check only one) മ examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 DOA 1 Yes 2 No After t 28a. Date of Injury (Month, Day,Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred Certification 1 V Natural 1 Yes 2 No Pending Funeral Director: etely filled in by the Accident 2 Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Wedical within 2 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 11, 2009 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar JUN 1 2 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 7, Marjorie Susan Kingery 2009 8:15 P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 85 Yrs. If Under 1 Year | If Under 24 Hrs. 4 Hrs. 8. Date of Birth 9. Birthplace (St. Min. July Pay, Year) 9. Birthplace (St. Mary Tand 1 □ M 2 🛛 F 578-32-5053

1 - For State Registrar **Physician** /Medical Examiner Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Engineer must be notified at once. Baltimore, Maryland 21215-0036 **Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran

P.O. Box

Marjorie Kingery

	Usual Residence of								
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Funeral	11. Marital Status		12. Was Decedent Armed Forces?		13. Was Decedent of	of Hispanic Origin? (Sp Juban, Mexican, Puerto	ecify Yes or No-	14. Race - Ar Black, Wh	merican Indian,
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	20a. Method of Dis	•	<b></b>	20b. Place o	of Disposition (Name of	place) -		20c. Location - City of	or Town, State
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0	examiner? 1 ☐ Yes 2	No	Hospital:	ent 2 ER/O	utpatient 3 □ DOA	Other: 4 🗌 Nursing Ho	me 5 Reside	nce 6 □Other (Sp	pecify)
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Sertific	<sup>1</sup> 3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		ury - At home, fa c. (Specify)	rm, street, factory, office	e	28f. Location (St City or Town	reet and Number or i , State)	Rural Route Number
Medical (	29a. Certifier (Check only one)	Certifying P	hysician: To the best miner: On the basis of and manner sta	f examination a	e, death occurred at the nd/or investigation, in m	e time, date and place, ny opinion, death occurr	and due to the c red at the time, d	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)
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ar			THE RESERVE AND ADDRESS OF THE PERSON NAMED IN COLUMN TWO IN COLUMN TO THE PERSON NAMED IN COLUMN TWO IN COLUMN TW	400					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup>2009 June 6. Bronislava Kuzulis 7:03 A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours | Min. | December 25,1925 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 1 □ M 2 🖺 F Months Latvia 119-26-5549 Usual Residence of Decedent 10b County 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 402 Hurley Avenue #203 20850 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married 1 □Yes 2 👿 No Specify: White Specify. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) D.C. Government Controller 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Konstance

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

June 12.

402 Hurley Avenue #203, Rockville, Maryland 20850

20c. Location - City or Town, State

72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it is the office Examiner must be notified at Baltimore, Maryland 21215-0036 and Mental Hygiene. filed w Hygie Health tem 27 Department of Heall Important: If item 2 any Injury or other Pages nent of

Physician

/Medical

Examiner

10a. State

Director

Funeral

<u>}</u>

Completed

Be

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Andrejs Lupsans

20a. Method of Disposition

19a. Informant's Name/Relationship (Type. Print)

Karlis Kuzulis/Husband

1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State

ess of person who completed cause of death (Item 23a) (Type, Print)

MORANO,

ORIGINAL

32. Registrar's Signature

**Funeral** 

Director

**Physician** /Medical Examiner

physician and the burial-trans atter for u ig be

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death

To the Funeral Director;

completely filled in by the f

4 Donation 5 Other (Spec	ify) Mon	tgomery Crema	torium,Inc. 2(	)09 Be	thesda,	Maryland
21. Signature of Funeral Service Lice	M01498	22. Name Rockvi Rockvi	and Address of Facility Rille, Inc. 30	obert A. Pur 00 West Mond 1d 20850	mphrey F tgomery	uneral Home Avenue
23a. Part1. Erver the disease, or con shock, or heart failure. List only	nplications that caused the deal					Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	_a. Clostridium	n Difficile	e Infection			days
resulting in death)	Due to (or as a consec					
Sequentially list conditions	<sub>b.</sub> Perirectal					months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a soneed	quel les off):				
that initiated events	e. Pancytopen					years
resulting in death) Last	Due to (or as a conseq	,				
	Myelofibros	sis				years
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown  Part II. Other significant conditions	23c. If yes, outcome of pregnance of the control of	al death 3 ☐ Ectopio death 5 ☐ Other	'specify)			lelivery Day Year  to the cause of death?  Probably 4 ☑ Unknown
				24a. Was an  - autopsy performed 1 □ Yes 2 🎛	prior to death?	autopsy findings available or completion of cause of ?
25. Was case referred to medical examiner?			26. Place of D	eath (Check only one)		
1 Yes 2 No	Hospital: 1 ☑ Inpatient 2 □	ER/Outpatient 3 ☐	DOA Other: 4 \(\sum \) Nursing	Home 5 ☐ Residence	e 6 □Other (Sp	pecify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how in	njury occurred	
3 ☐ Suicide 6 ☐ Could not to determined		ome, farm, street, factory)	ory, office	28f. Location (Street City or Town, St	and Number or late)	Rural Route Number,
29a. Certifier 1  ☐ Certifying P (Check only one)	hysician: To the best of my kno miner: On the basis of examina and manner stated.	owledge, death occurre ation and/or investigati	ed at the time, date and place on, in my opinion, death of	ace, and due to the caus ccurred at the time, date	e(s) and manner and place, and d	as stated. ue to the cause(s)
29b. Signature and title of certifier	- 1		9c. License number	29d.	Date signed (Moi	nth. Dav. Year)

065830

06

9901 Medical Center Drive, Rockville, MD 20850

2009

20b. Place of Disposition (Name of cemetery, crematory or other place)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of Marylan		rtment of l		Re	g. No. 2	109	18953
Physici /Medic		1. Decedent's Name (First, Middle, Last)  MASHA		KHI	ZVER		2, Date of Death Month JUNE	_	2009	3. Time of Death  09:16A M
Examir		4a. Facility Name (If not institution, give s GILCHRIST HOSPICE	CARE		TOWSON			4c. County	В	ALTIMORE
Funeral Director		220-35-9064	M 2☐ <b>X</b> F 7. Age (In yrs. I	87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 08/10/1	921	9. Birthp Coun	lace (State or Foreign try) BELARUS
e Maryland 3a-f show	Director	Usual Residence of Decedent  10a. State 10b. County  MD N/A	10c. City	y, Town or Loc	BALTI	MORE				0d. Inside City Limits 1  Yes 2  No
th with the 23a or 28 ust by no		10e. Street and Number 6958 MARSUE DRIVE	, APT.# 1-D			21215		g. Citizen of V		USA
ified within 72 hours after death with the Maryland filed within 72 hours after death with the Maryland Hygiene.  Street than "natural", or Items 23a or 28a-f show ant, the Medical Exaction of the M	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Nidowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 _Yes 2 W No If Yes, Give Year or Dates:		Vas Decedent of I f Yes, specify Cub □Yes 2 🙀 No	Hispanic Origin? (Sp ean, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - Americ ck, White, o	etc.
al yiallu ZIZIOUN should be filed within 72 hou and Mental Hygiene. s marked other than "natura uumatic event, the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give	lent's Usual Occu kind of work done DO NOT use retire	during most of work	ing	6b. Kind of Bu		·
Idental Hygiked other	To Be Co	17. Father's Name (First, Middle, Last)  NOKHUM	E	BINDMAN	1	18. Mother's Name	e (First, Middle, N	laiden Surnarr		BTAINABLE
Malth a	-	19a. Informant's Name/Relationship (Type YEFIM KHIZVER /				t and Number or Rui GE CIR.,#1				
S 75 = 0		20a. Method of Disposition  1 → Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)	emoval from State AR	PINGTO	sition (Name of Natory or other pla 1UNO CON	06/1	1/2009	BALTIMO	RE,	MD
DallIIIIC permit. Page Department of Important: If any injury or		21. Signature of Funeral Service License		22	. Name and Addr	ess of Facility SC STERSTOWN	ROAD - F	ON & B	ROS.	MD 21208
Physician /Medical		23a. Part 1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the deatle cause on each line.  Due to (or as a conseq	TC LL		ing, such as cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Death
ficate be executed minary physician and minary street burial-transit	edical Examiner	Sequentially list conditions, if any self-self-self-self-self-self-self-self-	Due to (or as a conseq	uence of):						
death certif e attending d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ■ No 9 □ ∪nknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o	Ideath 3	Ectopic pregnar Other (specify)	ncy			ate of deliver	rery Day Year
- D D	b	Part II. Other significant conditions cor	tributing to death but not res	ulting in the u	nderlying cause g	iven in Part I.		oacco use con		the cause of death?
The ate h	Completed	COPENARY APTER					24a. Was a autops perform	У	Were autoprior to codeath?	opsy findings available ompletion of cause of 2  □No
VICAL II siclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital:			ther:	th (Check only on			Hocoice
ng Phys fter this	ation: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time o Injury	28c. Inj	4 🗆 Nursing H	ome 5 ☐ Reside 28d. Describe he		her (Spec rred	ity) HOSPICE
LIVISION tal or Attendii s after death. al Director: A ed in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Special	ome, farm, str fy)	eet, factory, office		28f. Location (Si City or Town		ber or Rui	al Route Number,
To the Hospital or a within 24 hours after To the Funeral Dire completely filled in b	edical	(Check only one) 2 Medical Examination	sician: To the best of my kno ner: On the basis of examina and manner stated.		vestigation, in my	opinion, death occu	irred at the time, o	ate and place	, and due	to the cause(s)
To t with To t	Σ	29b. Signature and title of certifier	Din			04395		9d. Date signed TUNE	9,3	2009
5		30. Name and address of person who con DANIEUE DOBERS 31. Date filed (Month, Day, Year)	mpleted cause of death (Iter	n 23a) (Type,	Print) HAPLES	ST, SWITE	209 6	BALTIM	ere,	MD 21204
Sta	ate	31. Date filed (Month, Day, Year)	Augustrar's Slow	AGU						

Thomas Eugene Lockett Please Type or Promin Black Indelible Ink. Ensure All Copi re Legible. State of Maryland / Department of Health and Mental Hygiene 2009 18954 **UNK UNK** Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day June 3, 2009 1723 hrs aket Lugene Inomas \Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number Raltimore 100 Block of 28th Street 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Months Days Hours Country) Maryland Director 12 M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County iny 1 Lyes 2 No 10g. Citizen of What Country Director 10f. Zip Code 10e, Street and Number 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. or items? Armed Forces? 1 Never Married 2 Married Yes 2 Yes 2 No specify: If Yes. Give Year permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Widowed Divorced If item 27 is marked other than "natural", her traumatic event, the Medical Examiner 16b. Kind of Business/Industry δ. 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) carrows 21215-0036 aborev 18.Mother's Name (First, Middle, Maiden 17. Father's Name (First, Middle, Last tonie Mae Abraham Be (Street and Number or Rural Route Nymber, City or Town, State, Zip Code) 19h. Mailing Address 19a. Informant's Name/Relationship (Type, Print) ۵ 21060 Baltimore, MD Abraham 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemelery, Date 20a. Method of Disposition crematory or other place) 2 Cremation 3 Removal from State etro mportant Other Specify Donation 5 TORU 9 22. Name and Address of Far ility gnature of Funeral Serviçe Licensee Balto Helants Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as pardiac or respiratory arrest, shock, or heart Approximate Interva Between Onset and hysician failure. List only one cause on each line ledical Atherosclerotic cardiovascular disease Immediate Cause (Final disease \_xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last death certificate be executed and Physician/Medical X UNPENDED attending physician or use as the burial 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Day Year Ectopic pregnancy Month 23b. Was decedent pregnant in the Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown q Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Records, P.O. 1 Yes 2 No 3 Probably 4 V Unknown Completed by 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? 1 🗸 Yes 1 **✓** Yes 2 No 26 Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Other<sub>4</sub> Residence 6 Other: Scene examiner? Nursing Home 5 DOA Inpatient ER/Outpatient 3 this 1 🗸 Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) After Medical Certification: 1 X Natural Yes 2 No Director: Pending 24 hours after death. 2 Investigation 28f. Location (Street and Number or Rural Route Number, City Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 3 Suicide Could not be within 24 hours at To the Funeral I determined (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b, Signature and title of certifie June 4, 2009 O.C.M.E. 0 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Patricia Aronica-Pollak MD. Registrar's Signature 31. Date filed (Month, Day, Year State Registrar OCME

**ORIGINAL** 

DHMH 17 Rev 1/2001 **OCME 2006** 

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** June 9, 2009 3:05 PM Pamela Jean Lambert /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 19 Left Wing Drive Middle River Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 09/09/1947 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Hours Days Months Maryland 61 219 50 5031 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I's Medical Examination to notified Director 1 ☐ Yes 2 ☐ No Maryland Baltimore Middle River 72 hours after death with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 19 Left Wing Drive USA 21220 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify. 2 Specify: 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, It at Media once. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Allen Yoston Betty Jean Matheney ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (husband) 19 Left Wing Drive Middle River Maryland 21220 Roger L. Lambert Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem Gardens 6/13/2009 Baltimore County, Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility

Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex Maryland 21221 art1. Enter the disease, or sock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate ause (Final -un Year **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical the attending phase as the IF FEMALE yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by sign 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 □ Yes 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After this funeral of Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 2 Accident n 24 hours after death.

• Funeral Director: A pletely filled in by the fi death. 1 ☐ Yes 2 ☐ No Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 ho To the Fune completely f (Check only 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9103 Franklin Duins Balt: more mg 21237 Str. 2300 vask 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 1815 P<sup>M</sup> Thomas A. Lessner 06-09-2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Center Harford Bel Air 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12–31–1929 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 X M 2 □ F 79 Director 217-26-3598 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Director Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 841 Flintlock Dr 21015 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2X No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machinist Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be . Pages 1 and 2 should be fil ment of Health and Mental H tant: If item 27 is marked otf permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic evone. Edwin Lessner Gertrude Clayton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose Lessner (Wife) 841 Flintlock Dr Bel Air, MD 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 06-15-2009 Baltimore, MD 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Funeral Service (Cicelises Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Medical / r as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) nding physician and Due to (or as a consequence of) Physician/Medical as the t IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an perforr al or Attending Physician: Ts after death.
Il Director: After this certificated in by the funeral director, pa 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or ignestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one)

Registrar

29b. Signature and title

30 Name and address of pers

Jorge

Shuntree

and manner stated.

completed cause of death (Item 23a) (Type, Print)

egistrar's Signatu

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 2:39 AM 11 2009 ì JUNE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner SEWARS CI 1-1050 til ti mone If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay Year) 5/29/1951 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Country) **Funeral** 1**∑** M 2□ F 220-54-4358 58 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a State 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Yes 2 No Director MD Baltimore City Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6 208 South Payson Street 21223 USA or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Specify: White 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Inc. Monee. Maintenance Real Estate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Long Margaret Bryant ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 59 Randall Avenue, Halethorpe MD 21227 Henry Dasch 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-10-09 |Glen Burnie MD Atlantic Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Ambrose Funeral Home Inc. 1328 Sulphur Spring Rd. Arbutus MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** myourned disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and burial-transit Due to (or as a consequence of) attending physician for use as the buria Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death

9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 □No 1 ☐ Yes No 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mus . wow 2000 Baldwill Street 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Gener S. Spark

DHMH 17 Rev 1/2001

Registrar

Decoder's Name (Post, Misse, Lazy)   Vallet C. Long   Section of Death   Vallet C. Long   Section of Death	Decembers have first Action Later   Section 1997			•	pe or Print in Black ii State of Maryland / Dep Ce		lealth and M	_	ne 2009	189
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Main   Baltimore   Baltimore   City   190, 20 Code   100, Citizen of What Country   100, 100, Citizen of What Count	Beautiful Section   12   College (1-for 5-)   Teacher   12   College (1-for 5-)   Teacher   13   Mather's Name (First, Michiel, Meisten, Last)	Director		236-50-0954 Usual Residence of Decedent	76		Hours Min.	Dec 26, 1	1	
Comparison of Financial Squire Licenses   Comparison of Financial Comparison	Beautiful Section   12   College (1-for 5-)   Teacher   12   College (1-for 5-)   Teacher   13   Mather's Name (First, Michiel, Meisten, Last)	natural, or iteme 23a or 28a-f ehow dical Examinar mant be notified at	ector	MD Baltimore		ore City		100		1 ☑ Yes 2 □
Comparison of Financial Squire Licenses   Comparison of Financial Comparison	Beautiful Section   12   College (1-for 5-)   Teacher   12   College (1-for 5-)   Teacher   13   Mather's Name (First, Michiel, Meisten, Last)	23a or 2	rai Dir	1722 B Henry Avenue		21			USA	
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Comparison of Financial Squire Licenses   Comparison of Financial Comparison	Comparison   Com	ed other to	Be	17. Father's Name (First, Middle, Last)	J <del>+</del>	tea	18. Mother's Nam			11
Comparison of Financial Squire Licenses   Comparison of Financial Comparison	Comparison   Com	th and Me 77 is mark treumatic	<u>-</u>	19a. Informant's Name/Relationship (Type			and Number or Rui	ral Route Number, C		
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Sequentially list conditions.  If EFEMALE:  23b. Was dacedent pregnant in the past 12 months?  1   Yes 2   No 9   Unknown 9	Secuentially list conditions contribute to the cause of death of the past 12 months?    Per part	Departrimporta eny inju		21. Signature of Funeral Service Licensee Ronal 3 . W 12	e, Director	22. Name and Addre State Anat Baltimore,	oss of Facility Omy Board Maryland	655 West	Baltimore	Street
## and the property of the find laded events resulting in death   Last      The property of th	The state of the s	Medical	_	shock or heart failure. List only one framediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of).		_		,	Interval Between Onset and Death
Second   S	The participant of the participa	ohysicien and the burial-transit	ā	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events						
Second   S	autopsy performed?   1	y the ettending pached for use as	ysician/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 2  No	1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5		у			*
Second   S	Section   Street and Number or Rural Route Number, City or Town, State)   State and place, and due to the cause(s) and manner stated.   State and place, and due to the cause(s) and man	n signed b uld be deta		Part II. Other significant conditions contrib	buting to death but not resulting in the	underlying cause gr	ven in Part I.			
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 2 Se. Place of Injury - At home, farm, street, factory, office 2 Se. Certifier 2 Control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  2 Sec. License number 2 Set. Location (Street and Number or Rural Route Number, City or Town, State)  2 Set. Certifier 2 Set. Location (Street and Number or Rural Route Number, City or Town, State)  2 Set. Certifier 2 Set. Location (Street and Number or Rural Route Number, City or Town, State)  2 Set. Certifier 2 Set. Location (Street and Number or Rural Route Number, City or Town, State)  2 Set. Certifier 2 Set. Location (Street and Number or Rural Route Number, City or Town, State)  2 Set. Location (Street and Number or Rural Route Number, City or Town, State)  2 Set. Location (Street and Number or Rural Route Number, City or Town, State)  2 Set. Location (Street and Number or Rural Route Number, City or Town, State)  2 Set. Location (Street and Number or Rural Route Number, City or Town, State)  2 Set. Location (Street and Number or Rural Route Number, City or Town, State)  2 Set. Location (Street and Number or Rural Route Number, City or Town, State)  2 Set. Location (Street and Number or Rural Route Number, City or Town, State)  2 Set. Location (Street and Number or Rural Route Number, City or Town, State)  2 Set. Location (Street and Number or Rural Route Number, City or Town, State)  2 Set. Location (Street and Number or Rural Route Number, City or Town, State)  2 Set. Location (Street and Number or Rural Route Number, City or Town, State)  2 Set. Location (Street and Number or Rural Route Number, City or Town, State)  2 Set. Location (Street and Number or Rural Route Number, City or Town, State)  2 Set. Location (Street and Number or Rural Route Number, City or Town, State)	27. Manner of Death 1 Natural 2 Note of Injury 28b. Time of Injury at Work? 1 Yes 2 No 2 Note of Injury 28b. Time of Injury 28b. Time of Injury at Work? 2 Note of Injury 28b. Time of Injury at Work? 3 Suicide 4 Homicide 28c. Place of Injury - At home, farm, street, factory, office 28c. Location (Street and Number or Rural Route Number, City or Town, State)  28c. Certifier (Chack only one) 28c. Certifier (Chack only one) 28c. Signature and title of certifier 28c. License number 28c. License number 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 3 Suicide 4 Homicide 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 3 Suicide 4 Homicide 28d. Describe how injury occurred 28d. Describe how injury occurred 3 Suicide 4 Homicide 28d. Describe how injury occurred 3 Suicide 4 Homicide 28d. Describe how injury occurred 3 Suicide 4 Homicide 28d. Describe how injury occurred 3 Suicide 4 Homicide 28d. Describe how injury occurred 3 Suicide 4 Homicide 28d. Describe how injury occurred 3 Suicide 4 Homicide 28d. Describe how injury occurred 3 Suicide 4 Homicide 28d. Describe how injury occurred 3 Suicide 4 Homicide 28d. Describe how injury occurred 3 Suicide 4 Homicide 29d. Location (Street and Number or Rural Route Number, City or Town, State)  29d. Describe how injury occurred 3 Suicide 4 Homicide 29d. Describe how injury occurred 3 Suicide 4 Homicide 29d. Describe how injury occurred 3 Suicide 4 Homicide 29d. Location (Street and Number or Rural Route Number, City or Town, State)  29d. Location (Street and Number or Rural Route Number, City or Town, State)  29d. Location (Street and Number or Rural Route Number, City or Town, State)  29d. Location (Street and Number or Rural Route Number, City or Town, State)  29d. Location (Street and Number or Rural Route Number, City or Town, State)  29d. Location (Street and Number or Ru	ate has page 2		/				autopsy performe 1 Yes 2	d? prior to co	mpletion of cause
29a. Certifier (Chaeck only one)  29b. Signature and title of certifier (Chaeck only one)  29c. License number (Chaeck only one)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)	29a. Certiflier (Chack only 2) Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certiflier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  4940  29a. Certiflier (Chack only 2) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certiflier  29c. License number  29d. Date signed (Month, Day, Year)  060  778  788  788  788  788  788  788	fter this	To B	examiner? 1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending	1   Inpatient 2   ER/Outpat	of 28c. Inju	ner: 4 Nursing Hory at rk?	ome 5 Residence		(y)
-20000 Dt.51)	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  4940 Eastern Ave, Balt MD Z1ZZY (THBMe)	urs after des rai Director lled in by the		3 Suicide 6 Could not be determined	building, etc. (Specify)			City or Town, :	State)	
-20000 Dt.51) 06/03/0)	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  4940 Eastern Ave, Balt MD Z1ZZY (THBMe)	hin 24 hou the Fune npletely fi	Medical	(Check only 2 Medical Examine one)	r: On the basis of examination and/or	investigation, in my	opinion, death occur	rred at the time, date	and place, and due to	o the cause(s)
	4940 Eastern Ave, But MD 21227 JABITE,	CO To		· July		D	4729	9	Ob OS	5/09

09-04186 Daniel Laabes

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State of Maryland / Department of Health and Mental Hygiene

			1- For State Certificate of Registrar Certificate of Registrar		Req	No. 2000	9 1895
Med	Physic lical Exan	cian nine	1. Decedent's Name (First, Middle,Last)  Paniel Laabes		2. Date of Death Month	Day Year	3. Time of Death
			4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of D	May 26, 200	9 4c. County of Death	1050 hrs
			3300 Taylor Avenue	Baltimore	Catt	4c. County of Death	
	Funera Directo		5. Social Security Numbe(ink) 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Months Days Hours	Hrs. 8. Date of Birth(	(MM/DD/YYYY) 9. Birthp Foreign 1950 Count	
	Maryland 28a-f show any d at once.	for	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Local	ion	pec 2, 1		0d. Inside City Limits  1 Yes 2 No
)	n the Mar 3a or 28a	Direc	10e. Street and Number  3300 Taylor Avenue	10f. Zip Code 21236	10g.	. Citizen of What Country  USA	y?
•	17 215-UU36 Id be filed within 72 hours after death with the Maryland Aental Hygiene, Arked other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at once.	Funeral Director		is Decedent of Hispanic Origin? es, specify Cuban, Mexican, Pu	( Specify Yes or No- erto Rican, etc.)	14. Race - American White, etc.	
	5 72 hours al n "natural al Examin	eted by	or Dates:	Yes 2 X No specify: t's Usual Occupation (Give kind ost of working life, DO NOT use	of work done retired)unk	Specify: White 6b. Kind of Business/Inde	
	21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Completed	unk unk  17. Father's Name (First, Middle, Last) unk	18 Mother's Na	ame (First, Middle, Mai	iden Surramo) 11 m Is	
	Z1ZT; suld be fil Mental I: marked c event, i	To Be					
:	MD 27 d 2 should lth and Mei n 27 is man	-	O.C.M.E. 111 Po	Address (Street and Number enn Street Balt			
	Baltimore, MD 27 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic en		20a. Method of Disposition   20b. Place of Disposition   3 Removal from State   20b. Place of Disposition   3 Removal from State   4 Donation 5 X Other Specify: 1n State	tion (Name of cemetery,		Oc. Location - City or Tox	
2	Dair permit. Departrr Imports injury o		21 Sin store of Funeral ervice License St.	ame and Address of Facility ate Anatomy Boa Ltimore, Maryla	rd 655 Wes	st Baltimore	Street
	Physician /Medical Examiner		23. Part I. Enter the disease, it complices no that caused the death. Do not enter the failure. List only one cause on each line.  Imm. Late Cause (Final disease a. Methadone intoxicat	e mode of dying, such as cardia	c or respiratory arrest,		Approximate Interval Between Onset and Death
	Lammer		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.	TOIL			
		Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated				
	ecuted and - transit	_	events resulting in death) Last Due to (or as a consequence of):			0.0	
760	cate be executed physician and he burial - transi	Medica	X UNPENDED AMENDED 23a, P11, 27, 28  IF FEMALE: 23c. If yes, outcome of pregnancy	a-f,permE, g892			
Roy 687	ertifi ding e as t	Physician/	past 12 months?  1 Live birth 2 Fet.	al death 3 Ectopic preg		23d. Date of delivery  Month Day	Year
٥	w requires that the is been signed by the should be detached.	by	Part II. Other significant conditions contributing to death but not resulting in the un Hypertensive heart disease	derlying cause given in Part I.		co use contribute to the	
of Vital Records	The law requi icate has been page 2 should	Completed	SI .		24a. Was an autopsy performed	prior to comp death?	sy findings available pletion of cause of
-	ician: The certificate rector, page	Be	25. Was case referred to medical examiner?	26.Place of Death (Chec		No 1 ✓ Yes	2 No
of C	ing Physic After this uneral dire	P.	1 V Yes 2 No Impatient 2 ER/Outpatient			sidence 6 V Other: Sco	ene
jon	ttendin leath. tor: Al	ation	27. Manner of Death  1 Natural 5 Pending Investigation  28a. Date of Injury (Month, Day, Year)  Fd 5/26/09 Fnd 10:	1 - V - 1 - 1 - 1	28d. Describe how unk	injury occurred	
Division	pital or Attend ours after death. eral Director: filled in by the	Certification:	Suicide  6 X Could not be determined  Could not be determined  Specify)  Sound: Reside:	factory, office building, etc.	28f. Location (Street or Town, State) Baltimore	et and Number or Rural F	Route Number, City
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi completely filled in by the funeral director,	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred one)  2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	d at the time, date and place, ar n, in my opinion, death occurred	nd due to the cause(s)	and manner as stated	use(s)
		Σ	29b. Signature and title of certifier	29c. License number O.C.M.E.	1	d. Date signed (Month, Lay 27, 2009	Day, Year)
J			<ol> <li>Name and address of person who completed cause of death (Item 23a)</li> <li>Ling Li, MD Assistant Medical Examiner 111 Penn Street,</li> </ol>	Baltimore, MD 21201			
	Sta Regist		31. Date filed (Month, Day, Year)  32 Registrar's Signature				
OHMH OCME	I 17 Rev 1/20		ORIGINAL			<del></del>	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year LINSKY **Physician** 2009 5:59 PM JOSEPH JUNE /Medical 4c. County of Death 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE JOHNS HOPKINS BAYVIEW MEDICAL CENTER N/A 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Feb. 13,1907 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1⊠ M 2□ F Months 213-09-3657 102 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wedical Examinat must be notified at any injury or other traumatic event, the Wedical Examinat must be notified at any injury or other traumatic event, the Wedical Examinat must be notified at agone. 10a. State 10b. County 1 ☐ Yes 2 X No Colgate Director Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7918 Lansdale Road United States 21224 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Completed by 3 Midowed 4 Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Union 193 Boilermaker unkn 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Casimer Linsky Hattie Cielinska ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Abingdon, MD 21009 3007 Tiffany Trail (Nephew) Mr. Wayne Collins 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ₺ Burial 2 □ Cremation 3 □ Removal from State Moreland Mem. Park Cem. 6/12/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) RENAL **Physician** ACUTE /Medical Due to (or as a consequence of): Examiner DATS SEPS15 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dille to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the SBS IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 1 ☐Yes 2 ☐ No 1 □Yes 2 No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 → No 1☐Inpatient 2☐ER/Outpatient 3☐DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. agnature and title of certifier

17

State Registrar CHRISTINE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MATIVD

RES-DOD

4940 EASTERN AVENUE, BALTIMORE, MD. 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#17perFH.G892.6/12/09,WS
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Day **Physician** 9203AM las JUNE 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner AGNES HOSPITAL BALTIMORE 8. Date of Birth Aug 17, 1940 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Sex 1 M M 2 □ F 68 Yrs. Hours Min. 218-36-245 Months Days North Carolina Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Important: if item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaminer must be notified at once. 1√Yes 2 No Funeral Director Himore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 229 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 Black 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) vansportation river 17 Father's Name (First, Middle, Last) Mcneil 18. Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MCNe MD 21229 3rletta Ellamont to Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Pages ŏ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State idon 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatuje of Funeral Service Licensee Howe 4600 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such of cardiac or shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ARTERY CORONARY DISEASE DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any seeing to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Examiner Due to or as a consequence of attending physician and Due to (or as a consequence of) 68760, To the Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical Box ( IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal deat
4 Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.0. ☐Yes 2☐No 9 Unknown 9 HInknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown DIABETES HYPERTENSION Completed 24b. Were autopsy findings available prior to completion of cause of death? END 24a. Was an performe After this certificate 20 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural in 24 hours are:
the Funeral Director: After Aft 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P 23748 JUNE 11, 2009 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAJANI JAGANA, St AGNES HOSPITAL, 900 CATON AVENUE. BALTIMORE, MD 21229 32. Registrar's S State Registrar

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Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed

		State of Maryland / De			-	•				
	•	_ FOI	ertificate of D		-	1. No 2009	18962			
Physicia	cal	1. Decedent's Name (First, Middle, Last)  Amy Josephine May			2. Date of Death Month	Day Year	3. Time of Death			
/Medic Examin		4a. Facility Name (If not institution, give street and number) Union Memorial Hospital	4b. City, Town, or L	ocation of Death	June	4c. County of Death				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 224 28 0153 1 M 2 F 85 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) 03/15/192	Year) 9. Birtl	nplace (State or Foreign untry) ginia			
land ow if	Director	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or	Location				10d. Inside City Limits			
e Mary <b>3a-f sh</b> tiffed		Maryland Baltimore Essex					1 □Yes 2 □ No			
with th		10e. Street and Number 170 Orville Road	10f. Zip Code 212	21	109	g. Citizen of What Cor USA	untry?			
death	To Be Completed by Funeral		3. Was Decedent of His If Yes, specify Cuban		ecify Yes or No-	14. Race - Ame Black, White				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Evendor invest by notified at once.		1 ☐ Never Married 2 ☐ Married 1 ☐ ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 □ Yes 2X No	Specify:		Specify: W	hite /			
in 72 h n "natu		(Specify only highest grade completed) (Gi	cedent's Usual Occupat ive kind of work done du e. DO NOT use retired)	tion uring most of worki	ing 16	6b. Kind of Business/	Industry			
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wid be file Mental Hi arked oth		17. Father's Name (First, Middle, Last)  John Morrison			e (First, Middle, Ma ie Morris					
d 2 sho Ith and 77 is m traum			ailing Address (Street ar Torner Road			-	Zip Code)			
es 1 and of Health litem 27		20a. Method of Disposition 20b. Place of Dis	sposition (Name of rematory or other place,			Oc. Location - City or	Town, State			
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permit. Depart Import any Inj once.		21. Signature of Funeral Service Licensee	22. Name and Address							
	Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not shoot, or heart failure. List only one cause on each line.					Approximate Interval Between			
Physician /Medical		Immediate Cause (Final disease of condition resultand death)  a. Lover Extremty Dueg Ven through the Consequence of):  Onset and Death  (a. Lover Extremty Dueg Ven through the Consequence of):								
Examiner		R. Davis Co. F. M. C.						6 weeks		
ted sit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	. 40	h m			U			
te be executed ysician and e burial-transit	cal Exar	that initiated events resulting in death) Last  C. Due to (or as a consequence of):	35 (14)				1 (100)			
ifficate g physias the I	edica	d								
The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/Medi		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of del Month	ivery Day Year			
ires that the signed by I be detac		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death?  1				
w requir s been si should t	leted				24a. Was an	24b. Were au	utopsy findings available			
sician: The law certificate has rector, page 2 s	Completed				autopsy perform	ed? death? ☑No 1 ☐ Yes	completion of cause of			
ysicia: is certi directo	on: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpa		r.	h <i>(Check only one,</i> ome 5 ☐ Resider	oce 6 □Other (Spe	cify)			
ling Ph  After th funeral		27. Manner of Death 28a. Date of Injury (Month, Day, Year)  28b. Time (Month, Day, Year)	e of 28c. Injury Work?	at	28d. Describe hov					
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, to	Certification: To	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		es 2 No	28f. Location (Stre City or Town,	eet a <i>nd Number or Re</i> State)	ural Route Number,			
Hospital 24 hours Funeral etely filled	Medical C	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
To the Within To the соттрЫ	Me	29b. Signature and title of certifier	29c. License		29	d. Date signed (Mont	h, Day, Year)			
		Man Como		438946		June 9,	2009			
12		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Merc Co. 25 art. War Marroll Hojath, Mi								
Sta Registra		31. Date filed (Month, Day, Year)  32. Registrar's Signature  JUN 1 2 2009  Server S. Jan	w	1						

09-04601 Phyllis McGowan

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 18963

		For State	Certificate of Death			Reg. No.		
/ Physician/		. Decedent's Name (First, Middle,La	st)		Date of Death     Month	Day Year	3. Time of Death	
forical Examin		Phullic	McGOWAN		June 9, 200		2118 hrs	
		a. Facility Name (if not institution, gi	ve street and number)	4b. City, Town, or Location of	Death	4c. County of Dea		
		Northwest Hospital Center	er	Randallstown		Baltimore Co	ounty	
Funeral	5	. Social Security Number 6. S	Sex 7. Age (In yrs, last birt	hday) If Under 1 Year If Under	24Hrs. 8. Date of Birth	(MM/DD/YYYY) 9. E		
Director	1	71- 70 2070	M 2 XF 49	Yrs. Months Days Hours	Min. En L 11	1 10/n Fore	country) M	
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any	_	Usual Residence of Decedent  Oa. State  10b. County	10c. City, Town	or Location			10d. Inside City Limits	
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Maryland 28a-f show 1 at once.	اق	Ma, paiti	mule I har	10011STOWN	T 10	g. Citizen of What Co	nuntry?	
Mary 28a	Director	0e. Street and Number	C Cicala #10	10f. Zip Code	1,0	g. Gilizen di Wilat de	A.	
th the Maryland 23a or 28a-f sho notified at once		3926 Noxe	S Circle	1 21133		US	H	
n with	77	1. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	<ol> <li>Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican,</li> </ol>		14. Race - Am White, etc.	erican Indian, Black,	
or items	Š	1 Never Married 2 Marrie	1 Yes 2 No	ii ree, speeny daban, memean,		D	1 1/	
after	교	3 Widowed 4 Divorce	ed if Yes, Give Year or Dates:	1 Yes 2 No specify:		Specify:	Iack	
hours after "natural", Examiner		15. Decedent's Education (Specify		Decedent's Usual Occupation (Give a during most of working life, DO NOT	ind of work done	16b. Kind of Busines	s/Industry	
72 ho	ompleted	Elementary/Secondary (0-12)	College (1-4 or 5+)	during most of working me. Do Not	( / 4	1.1. [	- 1	
036 thin redic	립	12	4 A	cts. Keprese	ntative	Citit	inancial	
ed w ed w lygie other	ا ق	7. Father's Name (First, Middle, Las	ast) 18.Mother's Name (F			laiden Surname)		
21215-0036 Uld be filed within 7/ Mental Hygiene, marked other than	Be.	James R.	Mc Gowan	I Ch	narity	Miller		
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-fshranaire event, the Medical Examiner must be notified at once	_	9a. Informant's Name/Relationship	(Type, Print) (mother) 19	b. Mailing Address (Street and Num	ber or Rural Royte Num	ber, City or Town, St	ate, Zip Code)	
MD rd 2 shc lith and n 27 is numati		Virs. Charity	MC GOWAN 1	618 Kuxton	Ave. K	alto. M	d. 21216	
_ = = = = = = =		20a. Method of Disposition		of Disposition (Name of cemetery, tory or other place)	Date	20c. Location - City	or Town, State	
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other tr	- 1		Kellioval Ilolli State	Hour Comston	6/16/2009	Woods	awn Md	
Baltimo permit. Pag Department Important: injury or ot	- 1	4 Donation 5 Other Special Service Lice		22. Name and Address of Ea	, , , ,	111	0.0	
Balt permit. Depart Impor	- 3	Carol	I Will	Joseph L. Ku	ss tuner	u Home,	P. H.	
Physician	1	23a. Part I. Enter the disease, or con	nplications that a sed the death. Do neach line. Pulmonary th	ot enter the mode of dying, such as c	ardiac or respiratory arre	est, shock, or heart	Approximate Interval	
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ficate be er	/We	F FEMALE: 3b. Was decedent pregnant in the	23c. If yes, outcome of pregnancy			23d. Date of deli	very Day Year	
68 certification	jan	past 12 months?	1 Live birth  4 Pregnant at time of death	2 Fetal death 3 Ectopic	c pregnancy	Month	Day real	
Box 68 e death certif the attending ed for use as	Sic	1 Yes 2 No 9 V Unknow		5 Other (Specify)		İ		
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P.O. Box 687 ss that the death certific gned by the attending		v				s 2 No 3 F	Probably 4 🗸 Unknown	
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tal Recionary The certificate rector, page		25. Was case referred to medical		26.Place of Death	(Check only one)			
ion of Vital Records, P.O. Box 68 tending Physician: The law requires that the death certifiest eath. or: After this certificate has been signed by the attending the funeral director, page 2 should be detached for use as	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2 V ER/	Outpatient 3 DOA Other	Nursing Home 5	Residence 6 0	ther:	
n of V ding Phy After tl funeral	一市	27. Manner of Death	28a. Date of Injury 28b	. Time of Injury 28c. Injury at Worl	? 28d. Describe	how injury occurred		
ion tendin eath.	tio	1 V Natural 5 Pending		1 Yes 2	No			
0 5 5 5 V	ica	2 Accident Investig	28e Place of Injury - At home	farm, street, factory, office building, e	tc. 28f. Location (	Street and Number o	Rural Route Number, City	
Division of Vital Records, spiral of Vital Records, spiral or Attending Physician: The law requir hours after death.  Ineral Director: After this certificate has been so filled in by the funeral director, page 2 should 1	Certification:	3 Suicide 6 Could n	ot be		or Town, S	State)		
Divi		29a. Certifier 4						
Det iii iii	<u>i</u>	(Check only 1 Certifying Physical Certifying Physical Examination (Check only 2 Medical Examination)	ner:On the basis of examination and/or	investigation, in my opinion, death of	courred at the time, date	and place, and due t	o the cause(s)	
To To Com	Medical	29b. Signature and title of certifier	and manner stated.	29c. License number		29d. Date signed		
	-		11-1/	O.C.M.E.	OÇME	June 10, 2009		
Thrown M. King Thymo.								
	ſ	30 Name and address of person wh		altimore MD 2120	1			
		Theodore M. King, Jr., N			ZIGITIOTO, IVID Z 120	<u> </u>		
St Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signature	parket				
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 205 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Betty Potter Mogenhan June 8. 2009 1:28 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Agnes Hospital Baltimore N/A 8. Date of Birth (Month, Day, Year) Aug. 10,1927 9. Birthplace (State or Foreign Country) Missouri 5. Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2 □ F Months Days Hours Min. 520-24-7832 81 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location MD Baltimore 1 ☐ Yes 2 ☐ No Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1205 Circle Drive 21227 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurse Healthcare 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ralph Potter Alice Shoemaker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1205 Circle Drive, Halethorpe, MD 21227, use of Disposition (Name of Date 20c. Location - City or Town, State Joseph T. Mogenhan, Sr.Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 3 Removal from State Burial 2 Gremation Loudon Park Cemetery 6-12-2009 Baltimore, MD 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road, Arbutus, MD 21227 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final 8 hours Due to (vr as a consequence of): disease or condition resulting in death) Sequentially list conditions, if any leading to interest ause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): tibri Due to (or as a consequence cta IF FEMALE: yes, outcome of pregnancy ☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? 1 Yes 2 Wo 9 Unknown Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □ Yes 2 🕽 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Matural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

burial-trans attending physician for use as the burlal certificate has been signed by the irector, page 2 should be detached within 24 hours after death.

To the Funeral Director: After this certific. completely filled in by the funeral director, I the

**Physician** 

/Medical

**Examiner** 

**Funeral Director** 

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Completed

Be

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Physician/Medical Examiner

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Completed

Be

Certification: To

Medical

2 Accident

3 🗌 Suicide

29a. Certifier

4 Homicide

31. Date filed (Month, Day, -Year)

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lijury or other traumatic event, If a Medical Exercite to provide any lipury or other traumatic event, If a Medical Exercite to provide any lipury or other traumatic event, If a Medical Exercite to provide any experiment.

Physician

/Medical Examiner

Baltimore, Maryland 21215-0036

State Registrar 29b. Signature and title of certifier

6 ☐ Could not be

determined

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature MARIA

and manner stated.

MD

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

HUSPITAL

900 Caton

28f. Location (Street and Number or Rural Route Number, City or Town, State)

09-04427 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Oscar Murray State of Maryland / Department of Health and Mental Hygiene 2009 18965 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) Date of Death Physician/ Month 1231 hrs **Medical Examiner** June 3, 2009 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** 2613 Puget Street 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Director Country) MARYLAND 1 X M 2 F 213-20-1388 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d Inside City Limits 1 X Yes 2 No BALTIMORE imore, MD 21215-0036

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If tiem 27 is marked other than "natural", or items 23a or 28a-f sho or other trannatic event, the Medical Examiner must be notified at once. MARYLAND , or items 23a or 28a-f shor must be notified at once 10e. Street and Number 10g. Citizen of What Country? 1.S.A. 舀 2613 11 Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Divorced If Yes, Give Year MAY 17, 1945 Specify: BLACK 3 X Widowed 1 Yes 2 No specify: ş AUC 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) LIH GRADE TRANSPORTATION COURDINATOR 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CARLESTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VONDALEE COWLING (DAUCHTER) 6200 IVY MOUNT RD, BALTIMORE, MD 21209 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State Department of Important: 06/09/2009 BALTIMORE, MARYLAND BALTIMORE MATIONALCEM. 4 Donation 5 Other Specify 22. Name and Address of Facility
505694 H. BROWN JR. FUNERAL HOME
SI40 N. FUTON AVE., BALTIMUE, MD BIS 21. Signature of Funeral Service Licensee Miamo N. FULTON AVE, BALTIMORE, MD Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical UNPENDED AMENDED certificate has been signed by the attending physician rector, page 2 should be detached for use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Year Fetal death past 12 months? Pregnant at time of Other (Specify) 1 Yes 2 No 9 Unknown death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? Yes 2 V No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗹 Other: Scene ER/Outpatient 3 DOA After this ဥ 1 🗸 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural 1 Yes 2 No Director: d in by the f Pending 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) Homicide 29a. Certifier 1 [ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E June 4, 2009

DHMH 17 Rev 1/2001 OCMF 2006

Registrar

and address of person who completed cause of death (Item 23a)

OCME

Assistant Medical Examiner

Registrar's Signa

Laron Locke MD.

31. Date filed (Mark)

111 Penn Street, Baltimore, MD 21201

09-04194 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Joseph Moore State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Physician/ nt's Name (First, Middle,Last 2. Date of Death Month Day May 26, 2009 **Medical Examiner** 1220 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4126 Potter Street, Apt. 301 **Baltimore** 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY 9. Birthplace (State o 7. Age (In vrs. last birthday) **Funeral** Months Hours 950 Director Country) Usual Residence of Decedent 10a. State 10d. Inside City Limits 1 Yes 2 No 1 and 2 should be filed within 72 hours after death with the Maryland Director 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Black Armed Forces' White etc 2 Never Married Married Yes 4 Divorced If Yes, Give Year Widowed Yes 2 No ment of Health and Mental Hygiene.
tant: If item 27 is marked other than "natural",
or other traumatic event, the Medical Examiner. specify ል 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Kind of Business/Industr Completed Elementary/Secondary (0-12) College (1-4 or 5+) Attendant 18. Mother's Name (First, Middle, Maid nico Be ္ရ Print \ 20b. Place of Disposition City or Town. State grematory or other place) Pages 1 2 Cremation permit. Page Department o nation 5 Other Specify Hom ature of Funeral Service Licensee Approximate Interval the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart **Physician** only one cause on each line Between Onset and /Medical a. Hypertensive Atherosclerotic Cardiovascular Disease mediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED signed by the attending physician be detached for use as the burial of Vital Records, P.O. Box 68760, IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy Live birth Fetal death 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>6</u> Diabetes Mellitus Yes 2 No 3 Probably 4 ✔ Unknown Completed this certificate has been s il director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed' death? Yes 2 V No Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other<sub>4</sub> Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene ္ရ 1 🗸 Yes No After 27 Manner of Death 28a. Date of Injury (Month, Dey,Yeer) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 V Natural Division 1 Yes 2 No within 24 hours after death.

To the Funeral Director: Pending filled in by the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 To the Func Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Nedical** 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Signature and title of certifier 29b 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E. May 27, 2009 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 0CME 2006

State Registrar gistrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 15: 10PM Samuel Wilson Marlow 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner n/a Baltimore Union Memorial Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 ☑ M 2 ☐ F 219-10-4242 83 10-13-1925 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int. If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Mcdical Examination ust be notified at 1 XYes 2 No Funeral Director Baitimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21215 5404 Wabash Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1√ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑ No Specify: Specify: African-American ģ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Genologist Samuels Jewelry 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arie Marlow ျှ Beverly Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If Item 27 is any injury or other trau once. 5404 Wabash Avenue, Baltimore, MD 21215 Gene W. Marlow/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-16-09 Owings Mills, MD Garrison Forest Veterans 22. Name and Address of Facility Wile Funeral Home P.A. of Balto. Co. 21. Signature of Funeral Service Licenses 9200 Liberty Road, Randallstown, MD 21133 23a. Part. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician unknown vermonic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Prostate unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 □No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an performe 2 **N**No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes V□No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) funeral 27. Manger of Death 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who propleted cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

ANTICE

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Per FH 6892 6/12/09 JH
State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** May 23, 2009 IRM 1:00 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Future Care Homewood Baltimore 8. Date of Birth Dec 25, 1942 Pennsylvania If Under 1 Year if Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1**∑**M 2□F Months 66 219-50-2432 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hyglene.

Then to Health and Mental Hyglene.

The strain or it is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at the 1√2 Yes 2 □ No MD Baltimore Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 21217 USA 1931 W. Lafayette Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No if Yes, Give Year or Dates: 11. Marital Status 1 Never Married 2 Married Specify: black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 K Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation unk 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) volunteering unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William McClean Sr ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1931 W. Lafayette Avenue Baltimore, MD Moana Powell/niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any injury or 4 ☐ Donation 5 🔀 Other (Specify) in state 22. Name and Address of Facility 21. Signature of Euneral Service Licensee Ronald S. Wade, Director State Anatomy Board 655 W. Baltimore Street Per DVR Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Irijury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death Day Month in the past 12 months? 5 ☐ Other (specify) ned by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed d be det by 2☐No 3☐ Probably 4☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? res 2 2 No death? 1 ☐ Yes 2 No 1□ Yes 25. Was case referred to dical examiner? 26. Place of Deat Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 | Inpatient 2 ER/Outpatient 3 DOA မှ within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner Death 28c. Injury at Work? Certification: (Month, Day Year) 1 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 11/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifiei Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier s of person who completed cause of peath (item 23a) (Type, Print) ne and addre 00 W. Registrar's Signature 31. Date filed ( fonth, Day, Year) State JUN 1 2 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 5UN UNE 2059 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HEDGE GROYE TERN MONELOOME 8604 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🖫 F Hours 220-84-8755 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show other traumatic event, the Madical Examiner Lust be notified at 1 Yes 2 No Director MOWTGOMIERI 10g. Citizen of What Country? 10e. Street and Number ò than "natural", or items 23a Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Specify: ASI AN within 72 hours after 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) TRAVEL INDUSTRX Elementary/Secondary (0-12) College (1-4or 5+) TRAVEL 12 4 marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental I int: If item 27 is marked of 1000 ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 18604 HEDGE GROXE THNI - SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or or 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State NORBECK MEMPK 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Turn al Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Colon **Physician** resulting in death) /Medical Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed and Due to (or as a consequence of): physician al Box 68760, Physician/Medical as signed by the attending of the detached for use as IF FEMALE: ves, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) Ö 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ş 1 Yes 2 No 3 Probably 4 hknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has t autopsy performed page ? After this certificate funeral director, pag 1 ☐Yes 2 ☐No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 27. Manner of Death 1 ☑ Natural 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🗹 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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		1. Decedent's Name	e (First, Middle, L	_ast)							2. Date of De	eath	av	Year	3. Time of Death	1
Physicia /Medica		Ruth Cor	delia I	Parker							June '				12:05 P™	
Examine	er	4a. Facility Name <i>(l</i> 2924 East	_					4b. City, Balt		Location of Death		40	c. County	of Death		
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permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", any Injury or other traumatic event, Ite Mades Exance.		19a. Informant's N			o+ o-s \					and Number or Ru timore St					ip Code) 21224	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 2009 /Medical 4a. Facility Name (If not institution, give street and humber) 4c. County of Death 4b. City, Town, or Location of Death Examiner MA Date of Birth (Month, Day, Social Security Number **Funeral** Hours Year) 1 □ M 2 💢 F Months Days APril 212-20-036 Usual Residence of Decedent Yrs. Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturar", or items 23a or 28a-f show any injury or other traumatic event, it is Nortical Examiner must be notified at any injury or other traumatic event, it is Nortical Examiner must be notified at any once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 □ No Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Completed by 3 ₩ Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ 196. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informatic Name/Relationship (Type. Print) (90cl (1) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 22. Name and Address of Facility
CSECH L. RUSS
2772 Winn. such as ( 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service-License 23a. Part/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Motastatic Ovarian Carcinoma **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 X No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate I 1 ☐ Yes 2 Ø No I □Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 📈 No Other: 4 Nursing Home 5 Residence 6 10 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this c funeral dire Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🔀 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No ieral Director: A death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours after To the Funeral Dire Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier H4593

State Registrar 31. Date filed (Month, Day, Year)

Avonue Svite 203

oleted cause of death (Item 23a) (Type, Print)
WM. 2835 Smith

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 23e 76 79 and Department of 48 and Amenday Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** enora 30 /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner NorThwes BALTIMORE TRANDALLSTOWN If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Age (In vrs. last birthday) Year! **Funeral** 1 ☐ M 2 🖫 -26-022 FEBRUARY 18,1929 MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Evantions rust by Inclined at RANDALLSTOWN MARYLAND BALTIMORE 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number S.A COURTLEIGH Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: Specify: 13/ACK Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SELF EMPLOYED DAYCARE GRADE 18. Mother's Name (First, Middle, Maiden Surname) MN-UNKNOWN 17. Father's Name (First, Middle, Last) Be and Mental BEATRICE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any Injury or other trau 3 HANNA CT., WINDSOR MILL MICHELE L. JOHNSON CRANDDAIXHTER) mD20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State CARRISON FOREST CEM ON/DE/2009 CWINGS MILLS, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility

SCSEPH H. BROWN JR. FUNERAL HOME

3440 N. FULTONAVE, BALTIMORE, MD 21217 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months 1 ☐ Yes 2 1 No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ₫ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 2 ☐ No 2 Z NO 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Deatural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \text{Homicide} \) 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lamont C. Smith Northwest Hospital Ra

31. Date filed (Month, Day, Year) - 32 Registrar's Signature

t Hospital Randallstown,

Md. 21133

09-04064 Joseph Pittman Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hydiene

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PI	hysicia	_	<mark>Registrar</mark> 1. Decedent's Nam	e (First, Middle,Las	st)					2. Date Monti	of Death	/ Year	3. Time of Death
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	ineral rector		5. Social Security N		ex 7.	. Age (In yrs. Ia		If Under 1 Ye  Months Da		Min		Fore	Birthplace (State or un eign Country)
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ryland	a-f sh	횽	MD 10e. Street and Nu	Baltimon	Le	Dare	Inore	10f. Zip Code			10g. (	Citizen of What C	ountry?
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215-0036 be filed within 72 hours after death with the Maryland	or items 23a or 28a-f show any must be notified at once.	Funeral	11. Marital Status  1 Never Marri	unk _	12. Was Dece	dent Ever in U.s ces? 2X No	S. 13. W	as Decedent of H Yes, specify Cub	lispanic Origir an, Mexican, F	n? ( Specify Ye Puerto Rican, e	es or No- etc.)	14. Race - Am White, etc	nerican Indian, Black, :.
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iore, I	Department of Health and Me Important: If item 27 is ma injury or other traumatic es			Cremation 3		m State	Place of Dispo crematory or o	osition (Name of other place)	cemetery,	Date	2	0c. Location - City	y or Town, State
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09-04075	
Terry Parks	

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and I		O.C.M.E.	,	111	1 Penn	Street	Baltir	nore, M	aryland	21201	
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**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 1 per doc, 14,17,19a per fh g893 7-1-09 vt

State of Maryland / Department of Health and Mental Hygiene

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dical niner		Facility Name (If not institution,	give street and number)		4b. City	, Town, or La	cation of Dea			. County of	Death		
mei	TI	he Johns Hopkins	Hospital		Balt	imore C	City						
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lers	11	Marital Status	12. Was Decedent E	Ever in U.S.	13. Was Dec			(Specify Yes or Norto Rican, etc.)	10-	14. Race -			
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Stuart Eugene Riley 2009 18976 1- For State Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Year 2120 hrs Medical Examiner June 9, 2009 Stuart. Eugene Rilev 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Rear of 500 blk N. Highland Ave N/A 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Country) Days Months Hours Director 212-19-8323 NOV 4, 1977 MD 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 1 Yes 2 X No Johnston Smithfield NC 28a-f shov notified at once. Director 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number 242 Harris Road 27577 USA with 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. White, etc Armed Forces? 1 Never Married Married Yes 2 X No after White If Yes, Give Year 1 Yes 2 X No specify: Specify: Widowed Divorced ρ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Pages 1 and 2 should be filed within 72 hours nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natur: or other traumatic event, the Medical Examl 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ltimore, MD 21215-0036 Electrical Apprentice Electrical Contracting 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Riley Dona1d Be Donna 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Donald B. Riley, father 242 Harris Road Smithfield, NC 27577 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 X Cremation 3 Removal from State 06/12/09 Metro Crematory, Inc. Baltimore, MD Donation 5 Other Specify 21. Signature of Funeral Service Licensee Corge MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. Baltimore, MD 299 Frederick Road Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hea **Physician** Between Onset and failure. List only one cause on each line. 'Medical Death a. Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and transit Physician/Medical AMENDED UNPENDED attending physician or use as the burial Box 68760 23d. Date of delivery IF FEMALE: 23c. If ves. outcome of pregnancy 3b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o. Completed by Yes 2 No 3 Probably 4 ✔ Unknown ۵ Records. 24b. Were autopsy findings available 24a. Was an prior to completion of cause of certificate has performed? ✓ Yes 2 death? 1 V Yes 26.Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be Hospital: 1 Other<sub>4</sub> Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 DOA this 1 V Yes 28a. Date of Injury After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject pedestrian struck by vehicle Jun 9, 2009 2109 hrs Natural Yes 2 V No Pending To the Funeral Director: completely filled in by the 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) Rear of 500 blk N. Highland Ave, Baltimore, MD (Specify) Alley Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number **OCME** June 10, 2009 O.C.M.E. Name and address of person who completed cause if death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Theodore M. King, Jr., MD. 31. Date filed (Month, Day, Year) Registrar's Signature Registra

**ORIGINAL** 

09-04589
Estee Randolph

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Estee Randolph		State I- For State Registrar	of Maryland / Departn Certific	nent of Health and IV cate of Death	vientai Hygie	ne Reg. N	10. 20	00 1007
Physicia Medical Examin	n/	1. Decedent's Name (First, Middle Las	odalah		Mo	te of Death onth Da ne 9, 2009	LU	3: Time of Death 1100 hrs
prof.		4a. Facility Name (if not institution, giv	e street and number)	4b. City, Town, or Loca		16 9, 2009	4c. County of De	
Function	H	Sinai Hospital  5. Social Security Number 6. Se	7. Age (In yrs. last b	Baltimore irthday)   If Under 1 Year   If	f Under 24Hrs. 8. D	ate of Rirth (A	M/DD/VVVVI a	Birthplace (State or Foreign
Funeral Director		218-60-2189 15 Usual Residence of Decedent	2 F		Hours Min.	ug 2,	1951 1	Country) Carolina
w any		10a. State 10b. County	10c. City, Tow	0 - 11 -				10d. Inside City Limits
145 14 the Maryland as or 28a-f sho	Director	10e. Street and Number		10f. Zip Code		10g. (	Citizen of What (	
[45] 4 eath with the Maryland items 23a or 28a-f show ust be notified at once,		3816 Hillsde	ale Rd		207			CA
leath wi r items	Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	13. Was Decedent of Hispani If Yes, specify Cuban, Me			14. Race - Ar White, et	merican Indian, Black, c.
s after de iral", or niner m	۾		If Yes, Give Year or Dates:	1 Yes 2 No sp		Jac	Specify:	slack
72 houn	eted	15. Decedent's Education (Specify or Elementary/Secondary (0-12)	College (1-4 or 5+)	<ul> <li>Decedent's Usual Occupation ( during most of working life. DO</li> </ul>		one IIo	o. Kind or Busine	ess/industry
-003( I within giene. ther tha	Completed	17. Father's Name (First, Middle, Last)		Laborer	Nother's Name (First,	Middle Maid	oweeth	eart Caplo
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", e event, the Medical Examiner	a	Wille Kan	dolph	$\mathcal{C}$	hristin	ne	Bunu	m
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	ို	19a. Informant's Name/Relationship (T	ype, Print)	9b. Mailing Address (Street and	d Number or Rural F	Route Number	, City or Town, S	itate, Zip Code)
Baltimore, MD pernit Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumatiniury or other traumatinium or other traumatiniury or other traumatinium or other traumatinium or other traumatinium or other traumatinium or other traumatinium or other traumatinium or other traumatinium or other other or ot	Ì	20a. Method of Disposition  1 Burial 2 Cremation 3		e of Disposition (Name of cemete atory or other place)		20	c. Location - Cit	na
Itimore it. Pages I stiment of H ortant: If ii	-	4 Donation 5 Other Specify. 21 Signature of Funeral Service Licen	See /	22. Name and Address of F	Lo 15	109	Batti	moe, (YII)
	-	Sru- LI	towell or	4600 Like	tu pi	ohts	Ave, F	39Ho MI) 21201
Physician /Medical		23a. Part I. Enter the disease, or comp failure. List only one cause on ea	lications that caused the death. Do ch line.  Chronic alcohol		•			Approximate Interval Between Onset and Death
Examiner			Due to (or as a consequence of):	abuse with cir	INOSTS OF	the i	IVEI	
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Box 687 e death certific the attending p	Physician/	23b. Was decedent pregnant in the past 12 months?	Live birth     Pregnant at time of death	2 Fetal death 3 E	Ectopic pregnancy		Month	Day Year
BO) he death	hysi	1 Yes 2 No 9 Unknown	9 Unknown			20 - 5:4		
Division of Vital Records, P.O. B tal or Attending Physician: The law requires that the d. rs after death.  al Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached.	ğ	Part II. Other significant conditions	contributing to death but not resulti	ng in the underlying cause given	TIN Part I.	parameter 1		e to the cause of death?  Probably 4  Unknown
ords, w requires been as been a should	Completed				2	24a. Was an autopsy	prior	e autopsy findings available to completion of cause of
Reco	Com	=======================================				performer  ✓ Yes 2		h? Yes 2 No
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n of V ing Phy After th funeral d	٤	1 Yes 2 No 27. Manner of Death		Time of Injury 28c. Injury at			injury occurred	
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	Medical C	29a. Certifier 1 Certifying Physici	an: To the best of my knowledge, d					
F. W. D. 83	ğ.	29b. Signature and title of certifier	and manner stated.	29c. License nui	ımber	29	ld. Date signed	(Month, Day, Year)
		MM //	1	O.C.M.E		J	une 10, 2009	<del>-</del> -
ν.			Assistant Medical Examine		ltimore, MD 21	201		9
Sta Registr	te ar	31. Date filed (Month, Day, Year) JUN 1 2 2009	32. Registrar's Signature	backed				
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** VIRGINIA RUSSE LL 2009 11 5:00 June /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Franklin Woods Nursing Center Rosedale 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🔀 F Months 216 22 6985 84 June 22, 1924 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2€XNo Baltimore Essex Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21221 342 Ida Avenue Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: <u>^</u> 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Principal Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Earl Boyer Elizabeth Hill မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 352 Stillwater Rd. Baltimore, Maryland 21221 Anita Tarlton (Personal Rep.) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 6/15/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) <sup>22. Name and Address of Facility</sup> Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 21. Signaure of Funeral Service Lieansee ohn Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ATHEROSCLEROTIC HEART DISEASE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner LEART DISEASE CORONARY Sequentially list conditions, rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy Month Day in the past 12 months? 4⊡Pregnant at time of death 5 Other (specify) ☐Yes 2 No 9☐Unknown 9 □ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ COPD 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Be ( Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, After t within 24 hours after death

To the Funeral Director:

				,	
			24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No	
25. Was case referred to medical		26. Place of Death	(Check only one)		
examiner? 1 ☐ Yes 2 → No	Hospital:				
27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	(Month, Ďay Year) Injury M	Bc. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory building, etc. (Specify)	, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,	
	nysician: To the best of my knowledge, death occurred miner: On the basis of examination and/or investigation and manner stated				

29c. License number

40008

29d. Date signed (Month, Day, Year)

State Registrar

Medical

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9105 SQUARE DR BALTIMORE FRANKLIN

32. Registrar's Signature 31. Date filed (Month, Day, Year) JUN 1 2 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 3:00 AM 200 KODINSON מכו /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Hospita andalistour 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2 F Months Days Hours Min 242-50-1850 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location ns 23a or 28a-f sho 1 ☐ Yes 2 No **Funeral Director** Kaltimore 10e. Street and Numbe 10f, Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status nt of Health and Mental Hygiene.

If item 27 is marked other than "natural", or item or other traumatic event, the Medical Examination. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates: Be Completed by 3 ☐ Widowed 4 ☑ Divorced Blac 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) eacher 5+ years 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဥ oode 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Apt. 5. Baltimure, MDZ1207 625 Ingleside Ave. O4 Dauchter 1 Deborah Kabinson 20b. Place of Disposition (Name of cemetery crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. -09 butus Memorial Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Volume 21. Signature of Funeral Service Licensee ausi 23a. Part 1. Enter the tisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt-failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pulmonary **Physician** embelism disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner neumanic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mont Month Year 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. و م 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐No 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 6 Dother (Specify) Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 datural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 🗆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N.S. Rajapahse M.D

5 Repaparse M

25 Main Sty Suite 200

20057465

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician 5:09 PM MINIE lune 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner Baltimore ltimore pita If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 244-48-8615 1 □ M 2 ▼ F N. CARCLINA Director Usual Residence of Decedent 10d. Inside City Limits 10a. show event, the Medical Exarciner roust be notified at 1 Yes 2 □ No Director items 23a or 28a-f 10e. Street and Number Funeral . Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Race - American Indian, 11. Marital Status Black, White, et 1 Never Married 2 Married 1 Tes 2 If Yes, Give Year or Dates ٩ 1 ☐ Yes 2 No Specify ģ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during the. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Mudeone. y/Secondary (0-12) College (1-4or 5+) urse's Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 5 Other (Specify) of Funeral Service Licenses 100 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. shock, or the art failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) piratory **Physician** insufficeence /Medical Due to (or so a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed Se psis sician and burial-trans Due to (of as a consequence of). Box 68760. attending physician Physician/Medical the as IF FEMALE Jse 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 1 🗌 Yes 2 No 3 Probably 4 Unknown page 2 should Completed Coronary artery disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 □Yes Division of Vital Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 27. Manher of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Matural To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 □ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier and manner stated.

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

course 30. Name and ad ex of prison whrompleted cause of death (Item 23a) (Type, Print)

droi

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

Belvedere AUR- Baltimore Md 21215

June 7 2009

09-04613 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Valentin J. Rocca 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day June 9, 2009 Year Medical Examiner Valentin Joe Rocca 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Johns Hopkins Bayview Medical Center Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Min Months Davs Hours Director 214-98-4722 44 10/08/1964 1X M Usual Residence of Decedent 10c. City, Town or Location 10b. County Hanover York and 2 should be filed within 72 hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 17331 308 Carlisle Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 X Never Married Vec Yes 2 No specify: Widowed 4 Divorced If Yes, Give Year ş 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Chef and Mental Hygiene. 17. Father's Name (First, Middle, Last) Be Francis J. Rocca Marie H. Betlev 2 19a. Informant's Name/Relationship (Type, Print) other traumatic 12 Sprenkle Avenue, Hanover, Marie H. Seymore/Mother PApermit. Pages 1 and 2 sl
Department of Health ar
Important: If item 27
injury or other traums 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) Burial 2 X Cremation 3 Removal from State Donation 5 Other Specify: per DVR 21. Signature of Funeral Service Licenses Laura C. Hardesty, M01197 **Physician** failure. List only one cause on each line /Medical Immediate Cause (Final disease a. Methadone intoxication Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of). Examiner if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical 21 per FD g892 6/15/09 **#23a,27,28a-f, per ME** g X AMENDED XUNPENDED the attending physician ed for use as the burial -2892 6/29/09 TT requires that the death certificate be Box 68760, IF FEMALE: 23c. If yes, outcome of pregnance 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ ₫. Yes 2 24a. Was an

8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign CountryMaryland 10d. Inside City Limits 1 X Yes 2 No 10g. Citizen of What Country? U.S.A 14. Race - American Indian, Black, White, etc. White Specify 16b. Kind of Business/Industry Hospitality 18.Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Location - City or Town, State Ardent Cremation services | 06/12/2009 | Hanover, Maryland 22. Name and Address of Facility Ardent Cremation Services 7522 Connelley Drive, Ste.N, Hanover, MD 21076 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Death 23d. Date of delivery Day Yea 23e. Did tobacco use contribute to the cause of death? No 3 Probably 4 ✔ Unknown Completed Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of autopsy has death? performed? The 1 🗸 Yes this certificate ✓ Yes 2 No No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medical 26.Place of Death (Check only one) Be Other<sub>4</sub> Hospital: 1 / Inpatient 2 Nursing Home 5 Residence 6 Other ER/Outpatient 3 1 V Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Natural ybk Yes 2 X No Director: Pending Fd 6/7/09 lunk 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State)  $14 \quad Thomas \quad Ln. \label{eq:location}$ 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be Suicide residence (Specify) Sparrows Point, MD Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 11, 2009 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month) State Registra

ORIGINAL

Time of Death

1554 hrs

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. dent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year 2009 Month **Physician** 3 00 PM sernice /Medical 4c. County of Death Town, or Location of Death Examiner Baltimore If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day) 7. Åge (In yrs. last birthday) Yrs. If Under 1 Year 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Days Director 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or Funeral or items Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Tyes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No 2 Specify. 3 Widowed 4 □ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nat any injury or other traumatic event and once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 19b. Mailing Address (Street and Number or Route Number, City or Tow , State, Zip Code) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 P
Donation 5 Other (Specify) 3 Removal from State Signature of Funeral rvice Lice see 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SYNDROT **Physician** RESPIRATOR ACUTE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner EP Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Examine P Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Prince of the sertificate has been sinned by the attending attending to the serious attending to the seriou LOBAR PNEUMONIX MULTI P.O. Box 68760, burial-tran Due to (or es a consequence of) attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) ed by the 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed has been STROK 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 □Yes 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a, Certifier 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2003 09 RESODO 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

State Registrar CLAUDE BASS

31. Date filed (Month, 1944),

ELEN

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BLVD

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09-04486	
Eric Richardson	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar		Certifica	te of	Death			Reg.		009	1090
Physicia edical Exami	an/	1. Decedent's Name (First, Middle,Last)		D' - '	1			Month	of Death n D 5, 2009	ay Year	3. Time o 1255	
3		4a. Facility Name (if not institution, give	ric Thomas street and number)	Richa	urds (	o. City, Town, or	Location of D		3, 2008	4c. County of E	Death	
V .		Howard County General Ho	ospital			Columbia				Howard		
Funeral		Social Security Number     6. Sex	, ,	yrs. last birth	nday)	If Under 1 Year Months Day		24Hrs. 8. Date Min.	e of Birth(	MM/DD/YYYY) S	<ol> <li>Birthplace (St Country)</li> </ol>	ate or Foreign
Director			M 2 F	22	Yrs.	,			Ap	r 24, 1987		Florid
á		Usual Residence of Decedent  10a. State  10b. County	10c.	City, Town	or Locatio	n					10d. Insid	le City Limits
nd show a	L.	MD I	Howard				Col	lumbia			1Ye	es 2 XNo
farylar 28a-f 1 at on	Director	10e. Street and Number	· · ·		-	10f. Zip Code	-		10g.	. Citizen of What	Country?	
MD 21215-0036 2 should be filled within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show any martic event, the Medical Examiner must be notified at once.		12101 Gold Ribbon V	Vay					1044			U.S.A.	
th with	Funeral	11. Marital Status  1 X Never Married 2 Married	12. Was Decedent Ever Armed Forces?	in U.S.	13. Was	Decedent of Hi s, specify Cuba	spanic Origin? n, Mexican, Pi	? (Specify Ye: uerto Rican, e	s or No- tc.)	14. Race - A White, 6	American Indiar etc.	, Black,
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MD 21215-0036 d 2 should be filed within 7 lth and Mental Hygiene. n 27 is marked other than numatic event, the Medica	Be C	17. Father's Name (First, Middle, Last)	Thomas W. Rich	nardson			16.Motriel S I	Name (First, iv		na L. Beco	novich	
212 ould bould by I Ment is mark	To E	19a. Informant's Name/Relationship (Ty	/pe, Print )	196	. Mailing	Address (Stre	et and Numbe	er or Rural Roo		er, City or Town,		:)
		Thomas Richardsor				01 Gold R						
Baltimore, permit. Pages I and Department of Heal Important: If iten		20a. Method of Disposition  1 Burial 2 Cremation 3			f Dispository or oth	tion (Name of ce er place)	emetery,	Date	1	20c. Location - C	ity or Town, Sta	te
LimC Page tment tant:		4 Donation 5 Other Specify:		Δ		Crematory		Jun 08	, 2009		Glen Burni	e, MD
Ball permit Depar Impor injury		21 Signature of Eugeral Service Lipens	May FM NS	<b>12</b>	22. Na	ame and Addres	Funeral H	Home, P.A				
Physician		23a. Part I. Enter the disease, or compl		teath. Do no	t enter th	e mode of dying	, such as card	nbia Pike i diac or respira	tory arrest	City, MD 21 t, shock, or heart	Approx	imate Interval
/Medical		failure List only one cause on ear Immediate Cause (Final disease a.	Heroin into	oxicat	ion						Betwee	en Onset and Death
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्रज है	/Medical	X UNPENDED	AMENDED 23a,2	27 <b>,</b> 28a	-f,p	erME, g	892 6/	19/09	ГТ			
	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of		F-1	2	Ectopic p	Yeanancy		23d. Date of de Month	elivery Day	Year
Sox 68 death certiff	Physician	past 12 months?	1 Live birth 4 Pregnant at time	of death 5		al death 3 ner (Specify)		regnancy		Month	Day	r ca.
Box ne death of the atter	hys	1 Yes 2 No 9 Unknown	9 Unknown	-					Distant	acco use contribu	to to the course	of dooth?
tal Records, P.O. Box 68 cian: The law requires that the death certificate certificate has been signed by the attending ector, page 2 should be detached for use as	by F	Part II. Other significant conditions	contributing to death but	not resulting	g in the u	nderiying cause	given in Part			2 No 3	_	
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l Re	e Co	25. Was case referred to medical				26.Plac	e of Death (C	heck only one	Yes 2	NO 1	<b>∕</b> Yes	2 No
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	n: To	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b.	Time of Ir	<i>' '</i>   ·	ury at Work?		escribe ha	w injury occurred	Ĺ	
	atio	1 Natural 5 Pending 2 Accident Investigation	Fd 6/5/09		11:5	Jam	Yes 2 X N					
Division tal or Attendi rs after death. al Director: /	Certification:	3 Suicide 6 X Could not to	28e. Place of Injury - four	nd at			building, etc.	Co I	cation (Str Town, Sta UMD 1 &	te) 12101	Gold Ri	bbon Wa
Hospital 24 hours Funeral		4 Homicide  29a. Certifier (Check only)  Certifying Physicia	an: To the best of my kno	wiedge, dea	ath occurr	red at the time, o	date and place	-			s stated.	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) 2 ✓ Medical Examiner	On the basis of examinat	tion and/or in	nvestigati	on, in my opinio	n, death occu	urred at the tim	e, date ar	nd place, and due	e to the cause(s	)
FSFS	29b. Signature and title of certifier 29d. Date signature and title 29d. Date signature 20d. Date signature 20d. Date signature 20d. Date si						29d. Date signed		(ear)			
		Tatall.	- Holler	حر		0.0	.M.E.			June 6, 2009	<del>9</del>	
		30. Name and address of person who on Patricia Aronica-Pollak MD			iner	111 Penn S	Street Balt	timore MD	21201			
Y	tate		32. Registrar's Si								<del></del>	
Regis		31, Date filed (Month, Day, Year)	Ener A	Local	1							

		•	For State Registrar	State of Ma	_		tment of F ificate of I		Mental Hy	gien Reg. No	2000	)	8984
	Physici	an	1. Decedent's Name (First, Middle, Las	st)					2. Date of De	Da	ay Year	3. Tir	ne of Death
	/Media			JOHN			SALAMONE		JUNE	9,	2009		45 A M
	Examir	er	4a. Facility Name (If not institution, give	,	CEMPED			Location of Deat		40	No. 2 0 9 3. Time of 2:45  4c. County of Death HARFORD  9. Birthplace (State of Country)  Maryland  10d. Inside Cincle of Indian, Black, White, etc. Specify: White  14. Race - American Indian, Black, White, etc. Specify: White  15. Kind of Business/Industry  Construction  16ty or Town, State, Zip Code)  17. Maryland  18. Registry  19. Approximately  21. Approximately  22. No 3 Probably 4 0 0  23d. Date of delivery  Month Day  24b. Were autopsy findings prior to completion of cincle of completion of cincle of completion of cincle of completion of cincle of completion of cincle of completion of cincle of completion of cincle of completion of cincle of completion of cincle of completion of cincle of completion of cincle of completion of cincle of completion of cincle of cin		
	Funeral		FOREST HILL HEALS 5. Social Security Number 6. S		(In yrs. last birt		If Under 1 Year	EST HILI	8. Date of Bi	th			tate or Foreign
	Director		215-24-9024 <sup>1</sup> Usual Residence of Decedent	<b>X</b> M 2□ F	81	Yrs.	Months Days	Hours Min.	10/25/	1927 1927			
	yland now		10a. State 10b. County		10c. City, Town	or Loca	ition					10d. Insi	de City Limits
	a-fsh	ctor	MD Baltim	ore	Essex							1 🗆	Yes 2∑No
	or 28	Dire	10e. Street and Number				10f. Zip Code			10g. Ci	itizen of What Co	ountry?	
	s 23a	ral	64 Stemmers Ru				21221						
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examinar must be notified at once.	d by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 XN If Yes, Give Year or Dates:		_	as Decedent of H ∕es, specify Cuba □Yes 2⊠No	ispanic Origin? (S in, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	)-	Black, White	e, etc.	an,
2-(	72 h	letec	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a.	(Give ki	nt's Usual Occup nd of work done o	during most of wor	rking	16b. k	Kind of Business	Industry/	
12	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	' I	inte. Do	O NOT use retired	()		C	natruat	ion	
9	filed Hygi other ent, II	Be Co	17. Father's Name (First, Middle, Last)		Pa	TIICÉ	,r	18. Mother's Nar	ne (First, Middle			.100	
lan	Aenta Aenta rked tic ev	To B	Charles Salamone	e				Carmel:	la Abel	la			
lary	2 shot and h is ma auma		19a. Informant's Name/Relationship (7	Type. Print)	19b.	Mailing	Address (Street a	and Number or R	ural Route Numb	er, City	or Town, State, 2	Zip Code)	
≥ (	is 1 and 2 soft Health a item 27 is other trau		John Frommeyer/G	randson									
lore	ges 1 nt of H iffite or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	1		tion (Name of tory or other plac		Date		•		
菲	it. Pa rtmer rtant: njury		4 ☑ Donation 5 ☐ Other (Specify		Anatomy		s Registr						nd
Ва	Depa Impo any l		21. Signature of Funeral Service Scen	see					•		•	-	01076
			23a. Part 1. Enter the disease, or comp	olications that caused	the death. Do n						Tallovel,	Approx	kimate
-1	Physician		shock, or heart failure. List only of	. >		,	los c					Onset	and Death
	/Medical		disease or condition resulting in death)	d	consequence of	of):	con Z	emeer					
	Examiner		Sequentially list conditions	b									
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of	of):							
•	xecut and Il-tran	Examiner	that initiated events resulting in death) Last	cDue to (or as a	consequence of	of):		_					
68760,	tificate be executed g physician and as the burial-transit	Sal		d	,	.,.							
68	rtificat ng phy as the	ledical		u									
P.O. Box	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. Within 24 hours after death. To the Luneral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use.	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown	Fetal death		Ectopic pregnancy Other (specify)			4			Year
π, σ	s that ned b	by Pr	Part II. Other significant conditions co	ontributing to death but	not resulting in	the und	erlying cause give	n in Part I.	23e. Did	obacco	use contribute to	the cause	e of death?
Vital Records,	equire en sig vuld bi	ed b							10	Yes 2	□ No 3□ Pi	robably -	Unknown
ဝင	law re as be 2 sho	Completed							24a. Was				
<u>=</u>	Physician: The le this certificate ha ral director, page 2	Som							perfo	rmed?	death?		
Vita	ician: certifi ector,	Be	25. Was case referred to medical examiner?	Hagnital:			I out-		ath (Check only				
ō	Phys r this ral dir	은	1 ☐ Yes 2 ☐ No ☐ ☐ 27. Manner of Death	Hospital: 1 ☐ Inpatier 28a. Date of Injury	t 2 ER/Out	<u> </u>	3 DOA Othe	Nursing H				cify)	
0	ding th. After	텒	1 Natural 5 Pending 2 Accident investigation	(Month, Day,		njury	28c. Injury Work	rai Yes 2□No	26d. Describe	now inju	ry occurred		
Division of	Atter r deat ector: by the	iţi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur	y - At home, far	m, stree						ural Route	Number,
	tal or s afte al Din ed in	Certification: To	4   Horricide	building, etc.	(Specify)				City or To	wn, State	e)		
	e Hospit 124 hour e Funera detely fill	Medical	29a. Certifier (Check only one)  Check only 2 Medical Exam	ysician: To the best o iner: On the basis of and manner stat	examination and	, death o	occurred at the tin stigation, in my o	ne, date and place pinion, death occu	e, and due to the urred at the time,	cause(s date an	s) and manner a d place, and due	s stated.	use(s)
	To th Withii To th COMF	Me	29b. Signature and title of certifier				29c. License	number		29d. Da	ate signed (Mont	h, Day, Ye	ar)
			Diwb 50				D3:	2279		Jun	ne 10.	200	1
	10		30. Name and address of person who o					-		U			,
س				5 W. MACPE				IR, MD.	21014				
	Sta Registra	re l	2 July ou (month, pay, 16al)	OZ. Nedistrat	J Signature A	h	well						
DHN	/IH 17 Rev 1/20		JUN 1 2 2	32. Registrat	a p.	7							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 2009 11, 7:30 A M Dorothy Schechter June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Stella Maris Timonium | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) | JAN 24, 1930 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗙 F Indiana 311-28-9472 Director 79 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at 1 XYes 2 □ No Director N/A **Baltimore** MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21214 Completed by Funeral 2904 Whte Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 □Yes 2 XNo Specify: White 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Business Owner Clothing Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lora Belle Fulton Mack Watts ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2904 White Ave Baltimore, MD 21214 Mark N. Schechter/son permit. Pages 1 and Department of Healt Important: If Item 2 any Injury or other Baltimore. 20a. Method of Disposition
1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 6/12/09 Baltimore, MD 21. Signature of Funeral Service Licensee C. Todd Dring 22. Name and Address of Facility
Cremation Society of Maryland, Inc.
299 Frederick Rd Baltimore, DM 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death INKINSONS Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician: The law requires that the death certificate be executed Exami Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the pest 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an of Vital 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Residence 6 Other (Specify) 1 Yes 2 Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred I or Attending Parter death.

| Director: After the parter of the parter Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Exitiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. within 2 29b. Signature and tip 29c. License number 29d. Date signed (Month, Day, Year) JUNE 11, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDDIE NAKHUDA, M.D. 2300 DULANEY VALLEY ROAD TIMONIUM 21093 32 Registrar's Signature State known

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Lloyd, smith 2009 7:45 A M June /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** , marriand Bu Himore **Pfiquat** Randa | stewn Northwest If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12 16 38 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Days Hours 1√2 M 2 □ F Dírector 216-34-4956 70 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County show or than "natural", or items 23a or 28a-f show 1 Yes 2 □ No Director MD NA Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? death v Funeral 21207 3803 Bowers Ave U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 □Yes 2 □XNo Specify: Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event, Ite IM. Elementary/Secondary (0-12) College (1-4or 5+) Plant Protection Manager 12th grade Westinghouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Reaver Newman Lawrence Smith ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor H. Smith-Wife 3803 Bowers Ave, Baltimore, Md 21207 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, Md Garrison Forest Vet. 6/17/09 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licensee 4300 Wabash Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** WEEKS Pneumania disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Metastatic Tonsular Concer Y car Sequentially list conditions, if any, bearing to him ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of). and Mont Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy in the past 12 months? Month Day Year P.0. the 9 Unknown ģ ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ≥ Anemio 1 ☐ Yes 2 ☐ No 3 ☐ Probably Y Unknown Completed 24a. Was ar Were autopsy findings available prior to completion of cause of autopsy performe certificate 2 **N**O 1 ☐Yes 2 ☐No Division of Vital 1 ☐ Yes this certific al director, 25. Was case referred to medical Be 26. Place of Death (Check onl. one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 patient 2 ER/Outpatient 3 DOA Certification: To After thi funeral 27. Manner of Death

1 Natural

2 Accident 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) Injury 5 Pending n 24 hours after death.

e Funeral Director: A letely filled in by the fu investigation 1 ☐ Yes 2 ☐ No NOT HOD YCOIDIA 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ertify g P s ian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

If div 1 amirer: On the basis of examination and/or investigation in my opinion, death account at the cause (s). 29a. Certifier Medical completely aminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

the within To the

> State Registrar

29b. Signature and

Rupe) \ Va Ki
31. Date filed (Month, Day, Year)

VaKil

JUN 1 2 2009

MD

R2. Registrar's Signiture

30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Hospital

29c. License number

D0067620

29d. Date signed (Month, Day, Year)

21133

June 8, 2004

5401 old Court Road Randullstown, Marriand

Physician
/Medical
Examiner

3. Time of Death 1:45 P M

1 ☐ Yes 2 No

Approximate Interval Between Onset and Death

Year

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes P ☐ No

**Funeral** 

Director

Directo

Funeral

<u>۾</u>

Completed

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant of Health and Z7 is marked other than "natural", or items 23a or 28a-f show ral", or items 23a or 28a-f show permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any injury or other traumatic ex

Baltimore, Maryland 21215-0036

**Physician** /Medical **Examiner** 

burial-trar the Hospital or Attending Physician: The law requires that the death certificate be exec attending physician for use as the buria ed by the signed by after death Director: within 24 hours after dea To the Funeral Directo completely filled in by th

Division of Vital Records, P.O. Box 68760,

Examine Physician/Medical Completed Be Certification: To Medical

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 20<u>09</u> Month George Carroll Stull June 10 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death College View Center Frederick Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6-30-1940 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 1 M 2 □ F Months Days Hours Min. 213-40-1992 68 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Carroll MD Westminster 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2944 Old Taneytown Rd. 21158 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 □Yes 2☒No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status 1 Never Married 2X Married White If Yes, Give Year or Dates: 1 ☐ Yes 2 🛮 No Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Gas and Electric Foreman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gary Ulysses Stull, Sr. Addie Watkins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JoAnn Zepp Stull-wife 2944 Old Taneytown Rd. Westminster, MD 21158 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Zion United Cem. Shipley, MD 6-14-2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fletcher Funeral Home PA 21. Signature of Funeral Service License Thomas 254 E. Main St. Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) avasomyo Due to (or as a consequence of): Sequentially list conditions, any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of)

1 ☐Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ 110

27. Manner of Death

2 Accident

4 Homicide

Natural

3 ☐Suicide

9 Unknown

23b. Was decedent pregnant in the past 12 months?

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 9 Unknown

5 ☐ Other (specify)

Month Day

/10

1 Tyes

24a. Was an autopsy 1 ☐ Yes

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day, Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

29c. License number

126041

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a, Certifier (Check only one)

29b. Signature and title of certifier

5 ☐ Pending investigation

6 Could not be determined

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

26. Place of Death (Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Frederick MD 21702

29d. Date signed (Month, Day, Year)

Hemen State

31. Date filed (Month, Day, Year) JUN 1 2 2009

Shah

Thomas Johnson Registrar's Signature

Registrar

			For State Registrar	State of Maryland	Department of F		ental Hygiene Reg. No	41119	18988		
	nysicia Medic		1. Decedent's Name (First, Middle, Last	SMITH			2. Date of Death Month Da		3. Time of Death		
	xamin		4a. Facility Name (If not institution, give のうひ) らを(よいかる			POE. MD	71773 40	. County of Death			
	neral ector		5. Social Security Number 6. Se 2/4-68-2668 10	x 7. Age (In yrs. last 56	birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Moreth, Day, Year)	9. Birthplac	Ce (State or Foreign		
aryland	TE DE	7	Usual Residence of Decedent  10a. State 10b. County	// A Ba	own or Location			100	d. Inside City Limits 1 ▼Yes 2 □ No		
death with the Maryland	pe notifie	Directo	10e. Street and Number	Stopof	10f. Zip Code	1217	10g. Cit	tizen of What Country			
ter death	idical Examiner must be nutified at	Funeral Director	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▼No	13. Was Decedent of H	Hispanic Origin? (Specian, Mexican, Puerto F	cify Yes or No- lican, etc.)	14. Race - American Black, White, etc	n Indian,		
13-UUSO 72 hours after dea	al Exam	þ	3 Widowed 4 Divorced	If Yes, Give / Year or Dates:	1 ☐ Yes 2 No  6a. Decedent's Usual Occup	pation	16b. K	Specify: Sla	eck		
IQ Z I Z I 3 filed within 72 I Hygiene.	the Medic	Completed	(Specify only highest grad	de completed)  College (1-4or 5+)	(Give kind of work done life. DO NOT use retire	during most of working bled		isAble	d		
land A	2 6	To Be C	17. Pather's Name (First, Middler Last)	th		18. Mother's Name	(First, Middle, Maider	Sumame)	2055		
Mary nd 2 shou lith and M	other traumatic	-	19a Informant's Name/Pelationship (T	ype, Print)	19b. Mailing Address (Street	and Number of Aural	Route Number, gity	or Town, State, Zip C	(120 Z		
More, Pages 1 a	injury or othe		20a. Method of Disposition  1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify,	Removal from State	e of Disposition (Name of etery for ematory or other pla	OK 6/11/6	ate 20ct	acation - City or Town	m, State		
Darmit. P	any inju		21. Signature of Funeral Service Licens		22. Name and Addre	Fulton A	REPLY T	Brown 3 BAHO Md	JR. 1/ Hanc		
Bhusi	:-:		Impleciate Cau (Final	lications that ceus d the death. In cause on each line.	Do not enter the mode of dyi	ng, such as cardiac or	respiratory arrest,	- I	Approximate nterval Between Onset and Death		
Physi /Med Exam	dical		disease or condition posulting in death)	a. Due to (or as a consequen	ce of): 6E /LT/	VAL DI	SEASE				
betr	ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consequen							
of ou, the be execu-	ne burial-transit	Ical Exa	resulting in death) Last	Due to (or as a consequen	ice of):						
A DO ertificate	e as the		IF FEMALE:	20-14							
The law requires that the death certificate that shear signed by the attending physical transfer of the attending physical physic	should be detached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 Ectopic pregnanc	y		23d. Date of delivery Month D	y Day Year		
ires that the signed by	d be detac	þ	The state of the s	art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute  1 Yes 2 No 3 F							
TECOLUS e law requires has been sign	2 01	Completed	METASTASIS : 1	HEPATITIS C	_		24a. Was an autopsy performed?	24b. Were autops prior to comp death?	sy findings available pletion of cause of		
en: Th ifficate	funeral director, page 2 s	0	SACAAL DECK 25. Was case referred to medical	BITUS ULCE	= A	26. Place of Death	1 ☐ Yes 2 No		P□ No		
Of VICE Physician:	direc	To B	examiner? 1 🗌 Yes 2 🚵 No	Hospital: 1 Inpatient 2 ER		her: 4 Nursing Hon		6 □Other (Specify)			
SION C tending P death.	ne funera	atlon:	27. Manner of Death  1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	b. Time of 28c. Inju Wo 1	ny at 2 ork? ]Yes 2 □ No	8d. Describe how inju	iry occurred			
tal or Attricts after de	ed in by t	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	o, farm, street, factory, office	2	8f. Location (Street a. City or Town, Stat		Route Number,		
DIVISION C To the Hospital or Attending P within 24 hours after death.	pletely fill	edical		vsician: To the best of my knowle iner: On the basis of examination and manner stated.							
To t within	E CO	Σ	29b. Signature and title of certifier	mogneels,	MD 29c. Licen.	se number  13 14 BF		ate signed (Month, D	•		
2	<b>✓</b>		30. Name and address of person who control was a supply of the supply of	KATH, Mg	107	とていれいい	E, MO	31233	=7		
R	Sta egistr	-	31. Date filed (Month, Day, Year)	2009 Cereva	S. parl						

			1 - For State Registrer	State of Ma	ryland		artmen tificat					Reg. No.	711114	18989	
	Physici	an	1. Decedent's Name (First, Middle, La William F	<sup>st)</sup> 'inbar Swee:	nev						June 8	ath Bay	09 Year	3. Time of Death 6:22 A M	
/b	/Medic		4a. Facility Name (If not institution, giv		псу		4b. City.	Town, or	Location o	f Death	ounc c		County of De		_
	Examin	er	Genesis Layhill						Sprin				ontgome		
	Funeral Director		5. Social Security Number 6. S 237-05-8491	Sex 7. Age	(In yrs. Ia	st birthday) Yrs.	If Under Months		If Under 2 Hours	Min.	8. Date of Bir (Month, Da June 27,	1h 1922	9. Bi	inthplace (State or Foreign Sountry) th Carolina	
	and **		Usual Residence of Decedent  10a. State 10b. County		10c. City,	, Town or Lo	cation			<del></del> -				10d. Inside City Limits	_
	Maryti f eho	ro	Maryland Montgome	ery			F	lockv	ille					1 ☐ Yes 22 <b>€</b> No	
	r 28a	irec	10e. Street and Number				10f. Zip	Code				10g. Cit	izen of What C	Country?	-
	23a c	aiD	13019 Evanston S	treet					20853				ted Sta		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Modical Establish matter and the notified at ance.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 WWidowed 4 Divorced	12. Was Decedent E Armed Forces? 1 对Yes 2 DN If Yes, Give WW Year or Dates K		1	Was Deced f Yes, spe 1 ☐ Yes		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto F	cify Yes or No Rican, etc.)	)-	14. Race - An Black, Wh Specify: W	nite, etc.	
2	72 ho	eted	15. Decedent's E (Specify only highest gra	ducation ade completed)		16a. Deced	dent's Usu	al Occupa	ation during most	t of workin	ng	16b. K	ind of Busines	s/Industry	
2	han "	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	-		se retired	luring most )		,	Fod	oral C	overnment	
22	filed v Hygie thar ti int, th		17. Father's Name (First, Middle, Last	2		Engi	пеет		18. Mothe	er's Name	(First, Middle			Overnment	
Maryland	id be id be kad o	To Be	John Finbar Swee								Coltr				
ary	should Mand Mand	-	19a. Informant's Name/Relationship			1	_						or Town, State		_
Σ	and 2 salth a n 27 i		Paula Sweeney Ro	thfuss/Daug		Acres de la companya del la companya de la companya		Control by American	d Dri	manufacture.	4				_
ore	ges 1 t of Hi Hiter or oth		20a. Method of Disposition 1    Burial 2 □ Cremation 3 □	Removal from State	CO	ace of Dispo	matory or o	other plac	e) J	une	ite 11,		ocation - City o		
Baltimore,	t. Par ntmen rtant:		4 □Donation 5 □Other (Speci	Tean tea	Mem	klawn orial	Park		a of Facilit	2009	rt A			, Maryland	
Bai	Depa Impo any ir		21. Signature of Funeral Service Pice	M0149									gomery	uneral Home/ Avenue	
	Physician /Medical Examiner		23a. Part1. Effer the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	a. Myocard  Due to (or as a	e. ial l a consequ	Infarc ence of):		Je or dynn	y, such as		i lespitatory a			Approximate Interval Between Onset and Death	
. 092	ate be executed hysician and he burial-transit	cai Examiner	Sequentially list conditions, and the conditions of the conditions												
.O. Box 68	death certific e attending pl d for use as t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown										23d. Date of delivery Month Day Year		
<b>a</b>	uires that the de n signed by the a lid be detached f	þ	Part II. Other significent conditions	contributing to death bu	it not resu	Ilting in the u	nderlying (	cause give	en in Part I					to the cause of death? Probably 4 🏝 Unknown	
Vital Records,	: The law requires that the cate has been signed by th page 2 should be detache	Completed									24a Was auto perf 1 Yes	psy ormed?	prior t death	autopsy findings available o completion of cause of ? es 2 \( \) No	1
/ita	icien: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?							of Death	(Check only	one)			_
n of	ng Physiter this neral direction	2	1 ☐ Yes 2 ☒ No  27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day		ER/Outpatier 28b. Time o Injury		28c. Injun Wor	y at	2	me 5 Res 28d. Describe		6 ☐Other (Spiny occurred	Decify)	
Division	ai or Atte s after der ii Diracto	Certification:	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined	28e. Place of inju							28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospital or Attendir within 24 hours after deeth. To the Funeral Diractor: Al completely tilled in by the fu	edical (		hysician: To the best ominer: On the basis of and manner sta	examinat										
).	To the To the Comp	M	29b. Signature and title of certified	1100		4.10	. 1	D006	e number 4208				e 9, 20	onth, Day, Year) 109	
	1041		30. Name and address of person Saadia Husain,	millet cause of de 3227 B	eath (Item	23a) (Type, ce Roa	Print)	ilver	Spri	ing,	Maryla	nd 2	0906		
1	Sta Regist		31. Date filed (Month, Day, Year)		ır's Signal	ture	O Se	F							

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

10	
Sta Registr	

for State Registrar	State of W		ertificate of D			g. No.	09	18991
1. Decedent's Name (First,	Middle, Last) Helen Shar	on Sutheri	n		2. Date of Death Month June		Year	5: 04P M
4a. Facility Name (If not ins	titution, give street and number)		4b. City, Town, or Le	ocation of Death		4c. County of		
,	the Chesapeake			hicum		Anne	Arund	e1
5. Social Security Number		ge (In yrs. last birthday	/) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	16	9. Birthplac	e (State or Foreign
220-38-8798 Usual Residence of Decede		67 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Nov • 19	,1941	Mary	land
10a. State 10b. C	ounty	10c. City, Town or L					10d.	Inside City Limits 1 ☐ Yes 2 ▼No
Maryland	Anne Arundel			era Park		g. Citizen of Wh	at Country	
10e. Street and Number 284 Whist1	ing Pine Road		10f. Zip Code	21146		nited S	_	
11. Marital Status	12. Was Decedent	Ever in U.S. 13	. Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Sp	ecify Yes or No-		- American	
1 ☐ Never Married 2 ☐ 3 🛣 Widowed 4 ☐ Div	If Vac Give	No	**	Mexican, Puerto	Rican, etc.)	Black, Specify:	, White, etc. Whi	
	cedent's Education highest grade completed)	I (Giv	edent's Usual Occupati re kind of work done du DO NOT use retired)	ion ring most of worki		6b. Kind of Bus	iness/Indus	stry
Elementary/Secondary (0	0-12) College (1-4or	5+)	mputer Ope	rator		Stee	1 Ind	ustry
17. Father's Name (First, M	liddle, Last)		1	8. Mother's Name	(First, Middle, M	laiden Surname	)	
Nelson Tu	icker			He1	en Wagne	r		
19a. Informant's Name/Rel Christopher	1 1 27		iling Address <i>(Street an</i> Whistling			City or Town, S rna Par		
20a. Method of Disposition 1 □ Burial 2 □ Crem 4 □ Donation 5 🛣 Ot	ation 3 □ Removal from State her (Specify Entombmen		position (Name of ematory or other place)			Oc. Location - C	-	
21. Signature of uneral S	ervice Licensee	in l	22. Name and Address Duda-Ruck 7922 Wise	Ave. Du	ndalk, M	Maryland	212	
shock, or heart failure Immediate Cause (Final disease or condition resulting in death)	as, complications that huse b. List only one cause in each l a Due to (or as	a consequence of):	1/	tensio			lr.	nterval Between Inset and Death
Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	s a consequence of):	ne_					years
IF FEMALE: 23b. Was decedent pregnis in the past 12 months 1 ∐Yes 2 I Ji No 9 ∐ Unknown	■ I Live birth	2 Fetal death 3	B			23d. Date Mon	of delivery	
Part II. Other significant co	onditions contributing to death	but not resulting in the	underlying cause given	in Part I.				cause of death?
					24a. Was ar autopsy perform 1 ∐Yes 2	y prined? do	/ere autops rior to comp eath? Yes 2	y findings available bletion of cause of □No
25. Was case referred to mexaminer?					h (Check only one	9)		
1 Yes 2 No	Hospital: 1 ☐ Inpat	ient 2 ☐ ER/Outpat		· 4  Nursing Ho	me 5 Heside	nce 6 □Othe	r (Specify)	
	28a. Date of Inj Pending (Month, Di nvestigation		/ Work?	at es 2 □ No	28d. Describe ho	w injury occurre	d	
	Could not be determined 28e. Place of In building, e	jury - At home, farm, s tc. <i>(Specify)</i>	street, factory, office		28f. Location (Str City or Town	reet and Numbe , State)	er or Rural I	Route Number,
	ertifying Physician: To the bes edical Examiner: On the basis and manner s	of examination and/or						
29b. Signature and title of o	ng Park,		29c. License	number )6348	/	9d. Date signed June		ay, Year) 2009
Myung	Pana 22	S. Green	e Street	Baltim	iene M	150	201	,
31. Date filed (Month/Day,	1 2 2009 Setu	trar's Signature	arke					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 27,28a-f per me g892 06/11/09dhb 23a

Red, No. 899 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** May 25, 2009 MARGARET TURBUTT MARIE 11:00A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1218 West 37th Street None Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Jan 2, 1917 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XX Days Hours Min 92 Pennsylvania 212-38-0982 Director Usual Residence of Decedent r 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√XYes 2□No Directo Maryland None Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 2 any Injury or other traumatic event, the Medical Examinational Decompose. 1218 West 37th Street 21211 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: White Completed by Specify: 3XXWidowed 4 ☐ Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Personel Director Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence 2 Roberts Blanche Nicholas ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR 1218 West 37th Street Baltimore, Maryland 21211 Louise Larson 20a. Method of Disposition
1 ☐ Burial 2 1 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date GreenMount Crematory Baltimore, Maryland 5-28-09 4 ☐ Donation 5 ☐ Other (Specify) Inature of Funeral Service Licensee 22. Name and Address of Fa. Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Vos culen Piseise /Medical Due to (or as a consequence of): Examiner Advanced Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of, Exami and burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical as the l IF FEMALE: ase 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 ☑No Month Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 ☑ No hIC DLT certificate 195015 2 X No 1 Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{M-Residence} \) 6 \( \text{Other} \) (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1⊠Yes 2 No Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Leg injury during transfer from car to wheelchair. 28b. Time of 28c. Injury at Work? After Hospital or Attending 1 Natural 2 Accident 5 Pending death. 03/17/2009 4:00 p. M 1 ☐ Yes 2 XNo 124 hours after death.

e Funeral Director: A letely filled in by the fu investigation 6 Could not be determined 3 Suicide 8f. Location (Street and Number or Rural Route Number, City or Town, State) 1200 Block of W. 37th Street, Baltimore, MD Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Street 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5-27-69

State Registrar

31. Date filed (Month, Day, Year)

32, Registrar's Signature

3508 Barkst

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Balto. Mil 2122

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 0

		•	1 - State Registrar					Cer	tificate of	Death		R	eg. No.		
			1. Decedent's Name (First, Mid	dle, Last)			_					2. Date of Deat Month	th	Year	3. Time of Death
	Physicia		Nellie A. Mox	ev Ti	horne							June !	9, <sup>Day</sup> 20	09	11:57 PM <sub>M</sub>
	/Medic Examin		4a. Facility Name (If not institut						4b. City, Town, o	r Location	of Death		4c. Co	ounty of Death	
	LAGIIIII		Washington Ad	venti	st Ho	spita	1			Takon	na Pa	rk	Mor	ntgomer	У
Т	Funeral		5. Social Security Number	6. Sex		7. Age (In	yrs. last birt	thday)	If Under 1 Year			8. Date of Birth	) Vaar)	9. Birthp	place (State or Foreign
	Director		578-52-2268	1 🗆	M 2 <b>⊠</b> F	6	8	Yrs.	Months Days	Hours	Min.	(Month, Day 09/16/	1940	<b>GA</b> Cour	my/
			Usual Residence of Decedent					1		1					
	yland now		10a. State 10b. Coun	ty		10	c. City, Town	or Lo	cation					1	0d. Inside City Limits
	Mar- fied	ţo	MD Mon	gome:	rv		Takoma	a Pa	ark						1 XYes 2 No
	the 28a noti	Director	10e. Street and Number	-gome.	-1				10f. Zip Code			1	I0g. Citizei	n of What Cour	ntry?
	with Sa or								20912-	_			Unit	ed Stat	ces
	eath	era	6411 Eastern .  11. Marital Status		2. Was Dec	edent Ever	in U.S.	13. V	Vas Decedent of F f Yes, specify Cub	lispanic Or	igin? (Spe	cify Yes or No-	14.	. Race - Americ	
_	ter of item	Funeral	1 ☐ Never Married 2 K M	arried	Armed F 1 ☐Yes	orces? 2 📉 No						Rican, etc.)		Black, White,	etc.
2	hours after death with the Maryland tural", or items 23a or 28a-f show It Examiner must be notified at	þ	3 ☐ Widowed 4 ☐ Divorce	ed	If Yes, G Year or I	ive Dates:		1	l □Yes 2 🔀 No	Specify:			Sp	pecify: Whi	te
2-003b	atura	ted	15. Deced	ent's Educa	ation		16a.	Deced	dent's Usual Occup	pation				of Business/In-	dustry
2	in 72 in "in	ple	(Specify only high			(1-4or 5+)		(Give life. L	kind of work done OO NOT use retire	during mos d)	st of workin	ng	Own	Home	
7	with jene	Completed		'	College	(1-401 5+)	н	ome	maker						
0	filed Hyg Sthei		17. Father's Name (First, Middle	e, Last)			'			18. Moth	er's Name	(First, Middle,	Maiden Su	ırname)	
yıan	d be ental ced c	o Be	Champ Paul Ha	rhert						Wil	lie M	ae Haulb	orooks	3	
5	hould d Me mark matt	မ	19a. Informant's Name/Relatio		e Print)		19h	Mailin	ng Address (Street	and Numb	er or Rura	l Route Numbe	r. City or T	own, State, Zin	Code)
<u> </u>	d2s than 7 Is					a			L Easterr						
ი	t and Heal em 2 ther		Stanley C. The	orne/ n	usban						D	ate		tion - City or To	
ō	ges or o		1 🗆 Buriai 2 🗷 Crematio		moval from	State			sition (Name of natory or other pla			Jun 12			Maryland
	tant:		4 ☐ Donation 5 ☐ Other	(Specify)					ake Crema			2009	Dere	.5111107	
Бантіто	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, Its Medical Examiner must be notified at once.		21. Signature of Funeral Sorti	ectigers	9	Me	<b>v382</b>	22	<ol> <li>Name and Address</li> <li>Rapp Fune</li> </ol>	ess of Facili ral &	Crema	tion Se	rvice	s	
	g∪ = @ o		DUSMINE			m			933 Gist	Ave.	Silve	r Sprin	g, Ma	ryland 2	
			23a. Part 1. Enter the disease, shock, or heart failure. L	or complic	ations that	caused the each line.	death. Do	not ent	er the mode of dyi	ng, such as	s cardiac o	r respiratory ar	rest,		Approximate Interval Between
N	Physician		Immediate Cause (Final disease or condition	,	1	1 sto	120	C.	E llen	lung	er:			1	Onset and Death
	/Medical		resulting in death)	a.	Due to	(or as a co	nsequence	of):						-	11 11 11 11 11 11 11 11 11 11 11 11 11
	Examiner				Ĺ	Jan-	Col	Ü	Carran					- 1 A	truly blue
		ē	Se juentially list conditions, if any leading to immediate Due to (or as a consequence oi).									13			
	uted d ansit	Examiner	Cause. Enter Underlying Cause (Disease or injury												V
,	sician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	EXa	that initiated events resulting in death) Last	C.	Due to	(or as a co	nsequence	of):							
<b>68/6U</b> ,	e be sicia buri														
ģ	ficate phy s the	Medical		u.											
×	certi		IF FEMALE:	23	c. If yes, or	utcome of p	regnancy						23	d. Date of deliv	rerv
0	death ne atter ad for u	Physician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🕱 No		1 Live		Fetal death		Ectopic pregnant	су				Month	Day Year
o	the d	ysic	1 □ Yes 2 No 9 □ Unknown		g Unk		ic or dedar	JL	Graner (speedify)						
7.	requires that the been signed by th hould be detache		Part II. Other significant cond	itions cont	ributing to	death but no	ot resulting is	n the u	nderlying cause giv	ven in Part	I.	23e. Did to	bacco use	e contribute to t	the cause of death?
ecords,	signe be d	by	,				<b>3</b>		3			1 TY	′es 2 □	No 3∏ Pro	bably 4 Unknown
5	neen een	Completed													
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Ť	The ate har page	ĕ										perfoi 1 □Yes	2 Lavo	death? 1 □ Yes	2 🗆 No
Vital	lan: ortific ctor,	Be	25. Was case referred to medi	cal						26. Plac	e of Death	(Check only o	ne)		
	Physician: r this certific ral director,	0	examiner? 1 ☐ Yes 2 No	Ho	ospital:	Inpatient	2 □ ER/Oι	utpatier	nt 3 🗆 DOA Oti	ner: 4□N	ursing Ho	me 5 🗋 Resid	dence 6 l	□Other (Spec	ify)
0	g Ph ter th ter th	Ë	27. Manner of Death		28a. Date	e of Injury onth, Day, Ye		Time o	f 28c. Inju Wo	ry at	:	28d. Describe h	now injury	occurred	
<u></u>	ath. r: Aff	aţi	1 Natural 5 ☐ Pen 2 ☐ Accident inve	ding stigation	(1410	nin, Day, re		,,		Yes 2	]No				
DIVISION	Atte	iţi		d not be rmined	28e. Plac	e of Injury	- At home, fa	ırm, str	eet, factory, office		:	28f. Location (S	Street and	Number or Rui	al Route Number,
5	al or s afte 1 Dir	Certification:	4 D Hornicide		Dull	uirig, etc. (c	эреспу					Only of Ton	m, oldic,		
	To the Hospital or Attending Physician: Within 24 hours after death To the Funeral Director: After this certific completely filled in by the funeral director,								h occurred at the t						
State Registrar   State Regi						vestigation, in my	opinion, de	ath occurr	ed at the time,	date and p	place, and due	to the cause(s)			
	of the Yithir To the Young	Me	29b. Signature and title of cert	fier		, .			29c. Licen	se number			29d. Date	signed (Month	, Day, Year)
	,- >F 0		) ILL	RAAA	-	MID			b-	158	5015	>	Jan 4	12,73	307
7	1		30 Name and address of res	on who oc	mnleted ac-	ISB of docu	h (Item 23c)	(Type	Print)	-			1		. 23
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	4 °	to	31. Date filed (Month. Day Ye	ar)	12	Registrar's	Signature	A	- V - V (	/		1 1	, , , ,	-	
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	11091011		0011 1 0	<b>LUU</b> J	Mark	-	1. 13	-							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009 Month. **Physician** landine hompson /Medical 4b. City, Town, or Location of Death
Baltimore, 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 1075 164 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Min 13-36-6829 1 □ M 2 1 F Yrs Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, It e Modical Examinate must be notified at 1 Ves 2 No Director laryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Cher Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S 11. Marital Status 1 Dres 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 ☐ No Baltimore, Maryland 21215-0036 Specify: Black 2 No ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Inom 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship permit. Pages 1 and 2 s
Department of Health ar
Important; If item 27 is
any injury or other trau
once. Aberdeer Bevara armelita SMHA 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 1 ■ Burial 2 □ Cremation 3 Removal from State Esta 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fluneral Service Lice an 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner hrombocyto Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner fo the Hospital or Attending Physician: The law requires that the death certificate be execute physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical bitus s been signed by the attending p should be detached for use as: IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an s certificate has b lirector, page 2 sh autopsy performe 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death

1 Natural
2 Accident 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2009 mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** M /Medical 4b City, Town, or Location of Death 4c. County of Death Pacility Name (If not institution, give street and number) Examiner No If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday 6. Sex **Funeral** Min. 1 € M 2 □ F Months Days Hours 65 11-1-1943 Director 218-42-2954 S.C. Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Nedical Examiner must be notified an once. 1 TYYes 2 □ No Director MD N/A Baltimore 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code SA Funeral 635 Schroeder Street 21217 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 □ No 14. Race - American Indian, 11. Marital Status Black White etc. 1 ∏Yes 2 ☐ If Was, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 21 No Specify Specify: Black \$ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Sparrows Point 12th grade 3 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William U. Thomas, Donnavia Martin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donnavia Thomas-Mother 7169 Montgomery Road Eikridge, MD 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville Vet Crownsville, MD 6-11-2009 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March East F/H 21202 Y 1101 Ε. North Avenue 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine law requires that the death certificate be executed attending physician and for use as the burial-transi resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) ned by the a Ö 1 □Yes 2 □ No 9 Unknown σ. cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 2 🗀 No 3 Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy certificate 2 No 1 ☐ Yes Division of Vital Physician: funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? 2 No Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) 1∐Yes 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To Date of Injury (Month, Day, Year) 27. Nanner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t or Attending 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

**JUN 12** 

DHMH 17 Rev 1/2001

32. Registrar's Signature

			For State	State of Mar	yland /	-						2000	100	O 15
			Registrar			Cert	tificate o	Death	7		Reg. No	2003	105	70
	Physicia	an	1. Decedent's Name (First, Middle, Last)							2. Date of De Month	ath Da		3. Time of Dea	
	/Medic Examin		Dory Marion Timmons  4a. Facility Name (If not institution, give str				4b. City, Town,	or Location	of Death	June	40	2009 c. County of Dear	0310	
	Examilia	er	Peninsula Peninsul	matical	Cent		50	lishu	111	-		Wienn	ico	
	Funeral		5. Social Security Number 6. Sex	7. Age (	In yrs. last b	oirthday)	If Under 1 Year Months Day		24 Hrs. Min.	8. Date of Bir (Month, Da )ec 28,	th v. Year	9. Bir	hplace (State or Fo	reign
	Director		5/1-60-180/	M 2□F	64	Yrs.	World Day	- Trouis	t	ec 28,	194	4 Mar	yland	
	and bw		Usual Residence of Decedent  10a. State 10b. County	1	Oc. City, Tov	wn or Loca	ation						10d. Inside City Li	imits
	Mary f sho	ξ	MD Wicomico		Willa	rde							1 ∐Yes 2√g	] No
	r 28a	irec	10e. Street and Number		WIIIA	Lus	10f. Zip Code	,	<u> </u>	T	10g. C	itizen of What Co	untry?	
	th with	Funeral Director	7212 State Street					21874			Į	JSA		
	ems er mu	ne	11. Marital Status	. Was Decedent Eve Armed Forces?	er in U.S.	13. W	as Decedent of Yes, specify Cu	f Hispanic Or Iban, Mexica	rigin? (Spe	ecify Yes or No Rican, etc.)	-	14. Race - Ame Black, White		
20	s afte	by Fi	1 Never Married 25 Married	1 ☐ Yes 2 ☑ No If Yes, Give			□Yes 2 <sub>1</sub> N					Specify: Wh		
3-003p	hour tural	ed b	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Educa	Year or Dates:	16	a Decede	ent's Usual Occ	unation			16b k	Kind of Business	Industry 11nk	
0	iin 72 i. in "na iivedic	plet	(Specify only highest grade of	completed)		(Give k	ind of work don O NOT use reti	e during mos	st of workii	ng	100.1	and of Baomood	madelly diffe	
7	d with giene	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		car	rpenter							
and	tal Hy d othe	Be (	17. Father's Name (First, Middle, Last)					18. Moth	ner's Nam <i>e</i>	(First, Middle,	Maide	n Surname)		
<u>8</u>	ould to Meniarked arked	은	Dory Davis Timmons					Mild	red E	Burke				
Mai	12 sh h and 7 is m traum		19a. Informant's Name/Relationship (Type	*	- 1	_					-	or Town, State,		
_ ນົ	1 and Healt em 2		Sandy Timmons/spous  20a. Method of Disposition							ards, M		Land 218 Location - City or		
Dallino	Pages nent of ant: If it ary or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Rei	moval from State	cemet	tery, crema	ition (Name of atory or other p	lace)						
מו	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the modified Evaminer must be notified at once.		21. Signature of File Privice Licensee Ronald S. Wad	direct	or	Sta Bal	Name and Add ate Anat Ltimore	ress of Facili Comy B Mary	oard land	655 We 21201	st I	Baltimor	e Street	
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one	ations that caused the	e death. Do						rrest,		Approximate Interval Between	'n
F	hysician		Immediat Cause (Final disease or ondition		45	CVD							Onset and Deat	.h
,	/Medical Examiner		resulting in A ath)	Due to (or as a c			1			,				,
	-xammer	ī	Sequentially list conditions, if any, leading to immediate gause. Either University	Due to (or as a c			Failur	9						
	uted Insit	Examiner	Cause (Disease or injury	Duc to (0) as a c	onsequence	5 01).	PVD					51		
<b>.</b>	exec an and ial-tra	Еха	that initiated events c. resulting in death) Last	Due to (or as a c	onsequence	e of):								
000	hcate be executed physician and s the burial-transit	dical	d.											
9	ing ph	Med	IF FEMALE:								-1			
6	eath certific attending p for use as	ian/	23b. Was decedent pregnant in the past 12 months?	to the state of t	☐ Fetal dea		Ectopic pregna				-	23d. Date of de Month	livery Day Year	r
	he de	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at tir 9 ☐ Unknown	ne of death	5 📙	Other (specify)							
ŗ.	res that the de signed by the a be detached t		Part II. Other significant conditions contr	ibuting to death but r	not resulting	in the unc	derlying cause o	given in Part	L.	23e. Did t	obacco	use contribute to	the cause of death	h?
S C	pures n sigr lld be	d by								1 🗆 '	Yes 2	2 □ No 3 □ P	robably 4 Unkr	nown
2	sw require s been sig	lete								24a. Was	an	24b. Were at	utopsy findings avai	ilable
֓֞֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	scertificate has lirector, page 2 s	Completed								autor perfo 1 □ Yes	rmed?	death?	completion of cause : 2 □No	e of
<u>.</u>	certificate rector, pag	BeC	25. Was case referred to medical examiner?		_			26. Plac	e of Death	(Check only o		0 1 1 10108	20110	
> .	this co	2	1 ☐ Yes 2 ☑ No	spital: 1 ☐ Inpatient	2 ER/C	Outpatient	3 LL DOA		lursing Hor	me 5 Resi	dence	6 □Other (Spe	cify)	
	ding Phy h. After thi funeral o	ö	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Y	'ear) 28b.	Time of Injury	28c. In W			28d. Describe l	how inju	iry occurred		
<u>ה</u>	death death stor:	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	At home	form otro		□Yes 2□		OPf Location (	Cána aá a	and Museuba a a a D	ural Route Number,	
2	Verbital or Attending Prysician: The law requires that the death certificate be executed 44 hours after death.  Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification:	4 ☐ Homicide determined	building, etc. (	(Specify)	iaini, siiet	et, lactory, office	3	1	City or To	vn, Stai	na Number or A le)	urai Houte Number,	
	Io the Hospital of Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	edical	29a. Certifier (Check only one)  1 Certifying Physic 2 Medical Examine	r. On the hasis of ex	vamination a	and/or inve	estigation in m	oninion de	ath occurr	ed at the time	data ar	d place and du	to the cause(s)	
ř	withi To the	Ĭ	29b. Signature and title of certifier				29c. Lice	nse number			29d. D	ate signed (Moni	h, Day, Year)	
			NOIN				24	1709 4	4			6/9/09		
			30. Name and address of person who com		th (Item 23a	(Type, P	rint) V/5/UV	Sheel	2	84c151.	3LRI	y M	1 21804	
	Stat		31. Date filed (Month, Day, Year)	34. Registrar's	Signature	bar	Roll							
	Registra	110	HIM 1 7 7 HIG	L. Markey	Jun 1	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** une Robert Thomas /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctors Community Hospital Lanham Prince Georges If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** 1 3 M 2 □ F 214-30-0406 73 02/07/1936 Hyattsville, MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Marchal Exminer must be notified at any injury or other traumatic event, Ite Marchal Exminer must be notified at Director 1 Yes 2 No MD Prince Georges Landover 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7203 East Lombard St. 20785 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 to No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married timore, Maryland 21215-0036 1 ☐Yes 2 ☑ No Specify Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10th Sanitation Laborer Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Berdetta Hardman ဂ Benson Thomas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elsie M. Wallace/ Sister 7203 East Lombard St., Landover, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Glenwood Cemetery 6/12/2009 Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Fundal Service 22. Name and Address of Facility Johnson & Jenkins Funeral Home W, Washington, DC 20011 716 Kennedy St. NW, Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** espirato disease or condition resulting in death) /Medical **Examiner** D Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine burial-transif Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 arlure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed page 2 should peen inium 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? this certificate Dement Hospital or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes 2 NO Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident Director: filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MOD60611 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

8118

MD

GOEL LUCK RD LANHAM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Violette Elsa Thouvenin 2009 June 7, 8:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Olney

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth May 8 . 1915 Montgomery General Hospital Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 □ M 2 🖾 F 94 064-18-2243 France **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. Count 28a-f show ed other than "natural", or items 23a or 28a-f sho event, I'm "tedical Evening rual benedified at Maryland 1 Tyes 2X No Director Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8717 Deanna Drive United States 20882 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 X No If Yes, Give 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐Yes 2 No ş Specify: White 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) nd Mental Hygiene. marked other than Translator World Bank permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Item 27 Is manual Injury control of the should be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lucy Pauline Verliere Thouvenin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Taylor/Personal Rep. 374 Broadview Lane, Annapolis, Maryland 21401 Baltimore, June 13. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. 2009 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ 21. Signature of Funeral Service Ligenses Inc. 300 West Montgomery Avenue M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Se **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Delyelier tron Sequentially list conditions, if any leading to him plant cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine death certificate be executed physician and the burial-transit to Hirive Due to (or as a consequence of) Box 68760. Physician/Medical attending ph IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 **D**No Month 5 Other (specify) o the 9 Unknown The law requires that the 9 Unknown þ ۵. signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records. þ 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? To the Hospital or Attending Physici within 24 hours after death.

To the Funeral Director: After this ce completely filled in by the funeral direct 16 Inpatient 1 ☐ Yes 2 1 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0059414 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18101 Prince Philip Drive, Olney, Maryland 20832

State Registrar 31. Date filed (Month, Day, Year) 32. registrar's Signature S. Sanks

#### State of Maryland / Department of Health and Mental Hygiene 🛛 🔝 🖠 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Honth Year **Physician** ANITA. TORCHIN 2009 (th /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MORNINGSIDE ASSISTED LIVING HOWARD COLUMBIA Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🛣 F 088-12-7536 86 04/18/1923 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10c. City, Town or Location 10a. State ral", or items 23a or 28a-f show Director HOWARD MD COLUMBIA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5330 DORSEY HALL DRIVE #103 21042 Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: WHITE Baltimore, Maryland 21215-0036 1 □ Yes 2 No þ 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **AFROS** BENJAMIN FRANCES ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8 LINDA CAPLAN / DAUGHTER 5226 RACCOON COURT, COLUMBIA, MD Department of Health Important: If item 27 any injury or other tr 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State HILLTOP SERVICE CORP. 06/15/2009 TOWSON, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final · Kul monary CARDIO **Physician** disease or condition resulting in death) Due to (or as a consequence of):

1 Perteum on

Due to (or as a consequence of)

/Medical **Examiner** 

Examine

Physician/Medical

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Be

Certification: To

Medical

To the Hospital or Attending Physician: The law requires that the death certificate be execu Division of Vital Records, P.O. Box 68760,7 24 hours after death.

(	d			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		23d. Date of delivery Month Day Year		
	contributing to death but not resulting in the under	rlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?  No 3 Probably 4 Unknown
Hypothyraid PARKINSO	Nism		24a. Was an autopsy performed?	
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ER/Outpatient		me 5 Residence	ASSISTED  6 Souther (Specify) Living.
27. Manner of Death 1. Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)  28b. Time of Injury		28d. Describe how inju	ury occurred
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	hysician: To the best of my knowledge, death or miner: On the basis of examination and/or inves and manner stated.			
29b. Signature and title of certified	n n.	29c. License number	29d. D	ate signed (Month, Day, Year)

D. 30469

COLYMBIA.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

NY

USA

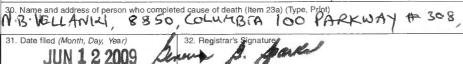
10d. Inside City Limits

1 □Yes 2 No

7.30 PM

State Registrar 31. Date filed (Month, Day, Year) JUN **1** 2 2009

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last



within 2.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month June Marcelyn Vydrzal To, 2009 10:42 pM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Alfred House Eldercare Montgomery Rockville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days 1 □ M 2 F Months Hours Min. 9/21/1930 Texas 456-46-4002 78 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 1 □Yes 2 No Montgomery Rockville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 18100 Cashell Road Room 6 20853 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Legal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Josef Vydrzal Louise Pavlicek 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2746 Count Rd.510Y Brazoria, TX 77422 Susan Wilson, niece 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Chesapeake Crematory 6/11/2009 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityRapp Funeral & Cremation Svcs. 21. Signature of Funeral Service Licensee M01539 933 Gist Ave. Silver Spring,
23a. Part 1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 933 Gist Ave. Silver Spring, MD 20910 Approximate Interval Between Onset and Death mmediate Cause (Final metastatic colon cancer months disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Uncertain g Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23d. Date of delivery Month Year Day use contribute to the cause of death? No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 ☐ Yes 6 ☐ Other (Specify)

**Physician** /Medical Examiner

Physician

/Medical

**Examiner** 

Director

Funeral

Be Completed by

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MD

**Funeral** 

Director

d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be motified at

nd 2 should be filed within 7 alth and Mental Hygiene.
27 is marked other than "1 rraumatic event, the Mar

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t: If item 27

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Important: If iter
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filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

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Physician/Medical Examiner Completed by Be Certification: To

burial-tra certificate has al or Attending P s after death. I Director: After i by the f

law requires that the death certificate be executed

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Division

MARCELYN

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1  Live birth 2  Fetal death	23d. Date of delivery Month Day Yea		
Part II. Other significant conditions o	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of deat 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unki		
		24a. Was an autopsy performed?  1 ☐ Yes 2 ☐ No		
25. Was case referred to medical	26. Place of Death	(Check only one)		
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Hom	ne 5 Residence 6 Other (Specify)		
27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year) Injury Work?  M 1 □Yes 2 □No	8d. Describe how injury occurred		
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	<ol> <li>Location (Street and Number or Rural Route Number City or Town, State)</li> </ol>		

To the Hospital within 24 hours a To the Funeral I

State Registrar 31. Date filed (Month, Day, Year)

Michael Grady MD 4201

29b. Signature and title of certifier

(Check only one)

Cathedral Ave NW; Washington DC 20016 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D38781

29d. Date signed (Month, Day, Year)

June 11, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 200°9 **Physician** James Stanley Wernsing II whe /Medical 46. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Glen Burnie Anne Arundel Baltimore Washington Medical Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 20 7. Age (In yrs. last birthday) 6. Sex **Funeral** Year Months Days Hours Min. 1**X**]M 2□ F 37 Yrs. 1971 Maryland 215-92-5250 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exerting It must be invitined at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 No **Funeral Directo** Anne Arundel Maryland Severn 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number **USA** 21144 410 Champion Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No White Specify: Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Heating & Air Condition Steamfitter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lynda DeMartin James Wernsing 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Champion Court Severn, Maryland 21144 Kara M. Wernsing, Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 06/10/09 Baltimore, Maryland Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 21. Signature of Funeral Service Licensee Thomas Gregor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Squantiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of Examiner burial-trar attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) certificate has been signed by rector, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) 1 Yes 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 patient 2 ER/Outpatient 3 DOA Medical Certification: To After this 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cartifier

Division of Vital Records, P.O. Box 68760, To the Hospital completely

or Attending Physician; The law requires that the death certificate be executed within 24 hours after death To the Funeral Director:

Maryland 21215-0036

Baltimore,

wernsing,

State Registrar

31. Date filed (Month, Day, Year

30. Name and address of

person who completed cause of death (Item 23a) (Type, Print

301 Registrar's Signatur